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2001

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Blankenstein, A. H. (2001). *Somatising patients in general practice: Reattribution, a promising approach*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

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# **Somatising patients in general practice**

**Reattribution, a promising approach**

The study presented in this thesis was performed at the Institute for Research in Extramural Medicine (EMGO Institute) of the Vrije Universiteit, the Netherlands. The EMGO Institute participates in the Netherlands School of Primary Care Research (CARE), which was acknowledged in 1995 by the Royal Netherlands Academy of Arts and Sciences (KNAW). The study was funded by the Netherlands Organisation for Scientific Research (NWO), council for medical and health research, grantnumber 940-33-016.

ISBN: 90-5669-056-6

Cover: Nettie Blankenstein / Liesbeth van Boxtel

Printing: PrintPartners Ipskamp, Amsterdam

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VRIJE UNIVERSITEIT

# **Somatising patients in general practice**

## **Reattribution, a promising approach**

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad van doctor aan  
de Vrije Universiteit Amsterdam,  
op gezag van de rector magnificus  
prof.dr. T. Sminia,  
in het openbaar te verdedigen  
ten overstaan van de promotiecommissie  
van de faculteit der Geneeskunde  
op woensdag 17 oktober 2001 om 15.45 uur  
in het hoofdgebouw van de universiteit,  
De Boelelaan 1105

door

**Annette Hendrina Blankenstein**

geboren te Leiden



Promotoren:        prof.dr. M. de Haan  
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                          dr. P.J.M. Portegijs

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# Chapter 1

## **General introduction**

## MOTIVATION

'To take responsibility for continuing, integral and personal care for the health of individuals and families who have entrusted themselves to him'<sup>1</sup>, is the credo, with which I was brought up as a general practitioner (GP). Although I have always worked as a part-time GP providing limited continuity in my presence during business hours, continuity of care over years, in a longstanding doctor-patient relationship which lasts over several illness episodes, has always been one of the attractive aspects of general practice for me. So it is hardly surprising, that the first research project in which I was involved, focused on patient-centred use of continuity<sup>2</sup>. We explored the role of GPs' fore-knowledge about patients, and we found that GPs' feelings towards patients played a major role in their diagnostic assessment and therapeutic approach. Frequently attending patients appeared to evoke strong feelings of sympathy or compassion, but also of antipathy, irritation or powerlessness, negative feelings which might hamper a trusting doctor-patient relationship and threaten good medical care. Apparently, continuity of care is not always an advantage. This finding encouraged me to search for interventions, which might enhance GPs' pleasure in difficult frequent attenders, restore a trusting doctor-patient relationship, and improve GPs' care for these patients. Mathers et al.<sup>3</sup> described that especially somatising patients, who frequently attend with multiple medically unexplained complaints, were often judged by their GPs as difficult, heartsink patients. In a one-day course the authors taught GPs strategies and consultation skills to survive the heartsink experience. For somatising patients 'retribution', a concise cognitive behavioural treatment, was proposed. Retribution stimulates somatising patients to link their physical symptoms to other causes than somatic disease. Retribution appeared to be applicable by trained GPs during office encounters<sup>4</sup>, and, within a few years, retribution was advocated in treatment guidelines on somatisation<sup>5</sup>. However, effects on clinical course had not yet been studied. We decided to design a randomised study to evaluate whether retribution, applied by (Dutch) GPs, is a feasible and effective treatment for somatising patients.

In the application procedure for a grant, another research group (ExTra, Maastricht), appeared to be preparing an intervention study for somatising patients (disclosure of emotional life events) as well. Co-operation between both research groups in Maastricht and Amsterdam resulted in a twin study on two different interventions for somatising patients in general practice. Both projects used identical definitions, criteria for patient selection, and measurement instruments, had a synchronic time-scheme, and made use of each other's data.

This collaboration between the two research groups is reflected in combined authorships for publications.

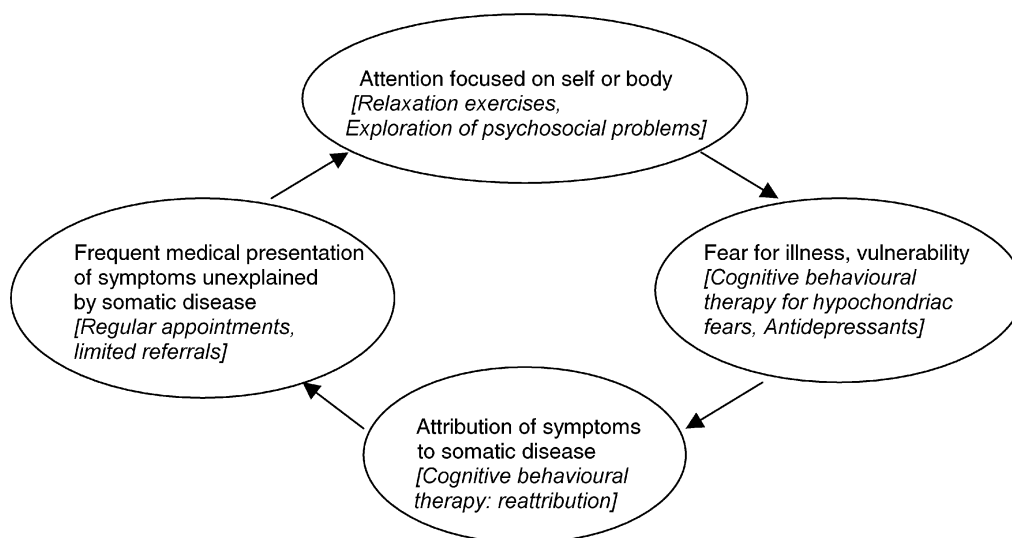
## **AIM AND RELEVANCE**

This study aims to contribute to a more effective treatment of the broad spectrum of somatising patients in general practice. Somatisation, defined by Lipowski<sup>6</sup> as ‘a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help for them’, is a major problem in medical care. In general practice, between 10% and 35% of all consultations concern patients whose illness behaviours fulfil the criteria of Lipowski’s definition<sup>7, 8</sup> : these patients report feeling unhealthy and their health care utilisation is increased.<sup>8, 9</sup> GPs report a need for effective therapeutic strategies.<sup>11</sup> Cognitive Behavioural Therapy (CBT) is widely recommended as treatment of choice for somatisation.<sup>12-14</sup> Reattribution, a short form of CBT for somatisation, has been developed for application by GPs.<sup>4, 15</sup> In 1994, when we designed our study, no randomised trial had been performed with reattribution performed by GPs; a controlled before-after study with reattribution was in progress.<sup>16</sup> In the Netherlands, reattribution was relatively unknown among GPs, and did not belong to their standard repertoire.

## **THE CONCEPT OF SOMATISATION**

The concept of somatisation can be discerned from the adjacent concepts of ‘psychosomatics’ and ‘somatic fixation’. Whereas the concept of somatisation focuses on the patient’s experience and expression of illness, psychosomatics are concerned with the psychosocial causation of somatic diseases. Somatic fixation refers to a circular process of persistent inadequate coping with disease, discomfort, symptoms or problems by patients, their family and social context, and their doctors, leading to unnecessary dependence on medical care, while the real problems are not addressed.<sup>17</sup> While somatic fixation emphasizes the interplay between the patient and his/her social context (doctors included), the concept of somatisation focuses on the patient’s cognitions and behaviours.

Lipowski's definition of somatisation consists of three elements: (1) the experience of somatic distress, explained by Lipowski as a normal reaction to stressful life events, which only becomes a clinical problem if accompanied by (2) inadequate cognitions (illness attributions) and (3) illness behaviours (communicate somatic distress and symptoms and seeking medical help). The way in which somatisation is developed and is maintained in peoples minds has been described by Robbins and Kirmayer<sup>12</sup> as a circular process. From Figure 1 it can be seen that four mental steps are recognised. Firstly the patient's attention is directed to him/herself and his/her own body, leading to amplification of somatic sensations. This induces fear for illness and a feeling of bodily vulnerability (hypochondriac fears). These anxious feelings give rise to cognitions: the bodily symptoms are attributed to disease causes. The patient may subsequently present to a physician with symptoms for which the doctor frequently finds no somatic pathological explanation. The symptoms, however, remain present, and this directs the patient's attention all the more to his/her body, resulting in a vicious circle of somatisation. Each of the four mental steps in the circular process of somatisation can be tackled by specific treatment approaches, as can be seen from Figure 1.



**Figure 1** Somatisation as a circular process (according to Robbins & Kirmayer<sup>12</sup>), with [in square brackets] therapies focusing on each point in the circle

While Lipowski's purely descriptive definition has been adopted widely, subsequent authors have added different considerations concerning the nature of somatisation. Often, somatisation is considered to be a psychiatric disorder, mostly accompanied by depression or anxiety disorder.<sup>10, 18</sup> Other authors have conceptualised somatisation as a personality trait, which has its roots in a troubled youth, and which becomes apparent during stressful periods.<sup>19</sup> In a third concept, somatisation is a useful way of coping with stressful life events, which prevents feelings of guilt and depression, and which only has the disadvantage that it may produce chronic somatic symptoms.<sup>20</sup> A different approach, which is frequently used in clinical medicine, is to avoid any concept of somatisation, and to label the medically unexplained symptoms as functional somatic syndromes, like irritable bowel syndrome, chronic fatigue syndrome, or non-cardiac chest pain syndrome. As early as 1982 Rosen et al. conceptualised 'three forms of somatisation'<sup>21</sup>, in which elements can be recognised of all three concepts discussed above. They discern acute somatisation, with a duration of a few weeks, which is considered as a way of coping with a stressful life event, from sub-acute somatisation, which lasts for a few months, and is related to a treatable psychiatric or social problem. Chronic somatisation lasts for years or even lifelong, and is related to chronic psychiatric or somatic disorders, which are associated with psychosocial problems. Goldberg has introduced the term 'facultative somatisers' for patients with (sub)acute somatisation, since he assumes that they can be brought to attribute their symptoms to other causes than illness, in contrast to chronic 'true somatisers', who stick more firmly to their illness attributions.<sup>19</sup>

In our study, we adopt Lipowski's broad definition of somatisation. We do not choose to split up somatisation into various disorders, like the DSM does, or into subgroups, like Rosen et al. have proposed. The broad concept of somatisation according to Lipowski, which comprises all forms of somatisation, resembles the way in which 'somatisation' is used by GPs. For our purpose, which is to develop a therapeutic tool for GPs, subdivisions are unnecessary: all forms of somatisation probably have similar influences on health, use of health care, and disability, and probably similar psychological processes are involved. Hypochondria is included in our concept of somatisation; hypochondriac patients are considered as somatising patients with prominent fear for illness and feelings of bodily vulnerability. Although we acknowledge that the longer patients have been somatising, the stronger they tend to stick to their illness attributions, we do not share Goldberg's assumption that chronic somatisers are necessarily 'true' somatisers. The more doctors develop their consultation skills, the more somatising patients may become 'facultative' somatisers.



Elements of Lipowski's definition of somatisation are reflected in the patient selection criteria of the study. The first element of Lipowski's definition, experience of somatic distress and symptoms unaccounted for by pathological findings, is represented by a score of five or more on the Somatic Symptom Index, which scores physical symptom according to the criteria of the DSM-III-R somatisation section<sup>18, 22</sup>. The second element, the presence of illness attributions, is measured with the Illness Attribution Scales<sup>23</sup> (no selection criterion). The third element, seeking medical help, has been made operational as a frequency of GP attendance of at least 15 times over the previous three years, which represents the upper 8% of attendance for the age group participating in our study, in Dutch general practice.

## **STUDY QUESTIONS**

In this study the reattribution model was modified to fit the broad spectrum of somatising patients seen in general practice, including longstanding somatisation and hypochondria. The following research questions are addressed.

1. What evidence is available, from randomised controlled trials performed in a general practice setting, about effectiveness of treatments for somatising patients?
2. Is application of the modified reattribution model by the patient's own GP feasible?
3. Is modified reattribution, applied by the patient's own GP, more effective than usual care in improving subjective health, reducing medical consumption, and decreasing sick leave, in frequently attending patients with five or more DSM-III-R somatisation symptoms?
4. What is the clinical course in somatising patients in general practice and what is the predictive value of stress-factors for clinical course over a two-year period?
5. Concerning the GPs' judgement on somatisation : (a) which aspects of communication, as perceived by the GP, contribute to the GPs' judgement of frequent attenders as 'somatising' or as 'difficult' patient, and (b) what is the predictive value of the GPs' judgement on somatisation (in comparison to standardised somatisation measures) for clinical course over two years?

## GUIDE TO THE READER

The thesis has been structured as a series of articles. Each article can be read on its own, which inevitably brings some repetition between the subsequent introduction and method sections. Chapter two addresses the first study question. This chapter consists of a systematic review of randomised trials on treatments of somatisation in general practice. The review has only been finished as the last part of the study, in March 2001. This allowed us to include two recent studies on CBT, whose results became available in 2000. Chapter three addresses study question two: three modifications to the reattribution model are described. These were developed in order to make the reattribution model, which was originally developed for early intervention, fit better to patients with longstanding somatisation and hypochondria as well. Feasibility of the modified reattribution model in Dutch general practice is evaluated. Chapter four, which answers study question three, reports on the core of the study: a randomised controlled trial on effectiveness of reattribution in general practice. The intervention consisted of the modified reattribution model described in chapter three. Chapter five addresses the fourth study question. Clinical course in the somatising patients included in both the Amsterdam and Maastricht part of the twin study, is described over two years, and the prognostic value of stress-factors in the patients life is evaluated. Chapter six, which reports on the fifth study question, focuses on the GPs' judgement on somatisation. Chapter seven discusses the methods, results and conclusions of the study; recommendations for further research and for general practice are provided. Finally, English and Dutch summaries of the study are given, and references which are used throughout the study are listed. As an aid to the reader, Appendix A gives an overview of the Maastricht and Amsterdam study profiles, showing which study population has been used for which study question; Appendix B lists the measures used in the study, and Appendix C shows the patient questionnaire on the main outcome variables. In Appendix D, the core texts from the syllabus for intervention GPs is reproduced, in which the principals of reattribution and dealing with persistent illness worry are described [in Dutch].

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## Chapter 2

### **Effectiveness of treatments for somatisation in general practice, a systematic review**

AH Blankenstein, HE van der Horst, AF Schilte, JC van Keimpema, M de Haan.  
*This chapter is currently being elaborated as systematic review for the Cochrane  
Collaboration Depression, Anxiety and Neurosis group*

## ABSTRACT

**Objective** To systematically review all randomised controlled trials of treatments for somatisation, which are either performed in general practice or applicable in general practice.

**Search strategy** 1. Electronic search of the bibliographic databases Medline, PsycINFO and Embase. 2. Electronic search of the Trials Register of the Cochrane Collaboration Depression, Anxiety and Neurosis group. 3. Peruse of references and related articles of relevant studies and reviews to find other relevant trials. 4. Contact with researchers in the field to retrieve missing trials.

**Study selection** Two independent assessors selected randomised controlled trials in which any treatment other than usual medical care was compared to usual medical care, or placebo in case of pharmacological trials, in adult patients with somatisation (either the broad spectrum of somatoform disorders, or somatisation disorder, or hypochondria).

**Data collection and analysis** Methodological quality was assessed by two reviewers independently, with Jadad's quality assessment scale, ranging from zero to five. Effect size was defined as change in the intervention group from baseline to follow-up in terms of percentage of the baseline value, minus the change in the control group. Pooling was not performed.

**Results** Ten randomised trials were included. Four trials which studied psychiatric consultation letters (PCLs) to general practitioners (GPs), showed decreased health care utilisation with little influence on symptoms or health. Two pharmacological trials showed small effects without clinical relevance. Four trials on cognitive (behavioural) therapy (C(B)T), applied by other professionals than GPs, showed moderate to considerable improvement of symptoms, health, and health care utilisation. Outcome measures varied greatly among studies. Follow-up periods varied from six weeks to one year.

**Conclusions** Management as formulated in psychiatric consultation letters can be applied by GPs to restrict health care utilisation in difficult, chronic relapsing somatising patients. CBT seems a promising approach which can improve symptoms, health and health care utilisation; randomised trials are needed in which CBT is applied by GPs.

## INTRODUCTION

Somatisation, defined by Lipowski<sup>1</sup> as a tendency to experience and communicate somatic distress and symptoms, unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help for them', is a major problem in medical care. In general practice, between 10% and 35% of all consultations concern patients whose illness behaviours fulfil the criteria of Lipowski's definition<sup>2,3</sup>: in these patients somatisation affects subjective health, and health care utilisation is increased<sup>4,5</sup>. Somatisation forms a continuum, with mild to disabling symptoms, with a short-term or a chronic-relapsing course, with or without hypochondriac illness worries, representing different somatoform disorders including hypochondriasis. Development and persistence of somatisation have been described as a circular process, in which four mental steps can be recognised.<sup>6</sup> Firstly the patient amplifies somatic sensations (1). This induces fear for illness (2), which in turn gives rise to dysfunctional cognitions (3): the bodily symptoms are attributed to disease causes. The patient may subsequently present symptoms for which no somatic pathological explanation can be found (4). Persistent symptoms, however, direct the patient's attention all the more to his/her body, resulting in a vicious circle of somatisation.

Most somatising patients are cared for in general practice. General practitioners (GPs) often describe somatising patients as difficult<sup>7,8</sup>, and they report a need for effective therapeutic strategies<sup>9</sup>. Many treatment approaches for somatisation have been proposed, which focus on one of the above mentioned four mental steps in the circular process of somatisation. Diminution of the preoccupation with bodily sensations can be achieved by relaxation exercises or by explanatory therapy<sup>10</sup>. Roots of the patient's tendency to focus on the body can be explored by analysing youth problems<sup>11</sup>. Fear for illness can be challenged by cognitive behavioural therapy (CBT)<sup>12</sup>, or be decreased by antidepressant medication. Misattribution of symptoms to somatic disease can be challenged by CBT (Reattribution)<sup>13</sup>. The actual somatic symptoms are often resistant to medical treatments, and strategies focus on restriction of non-appropriate medical consumption by case management, which implies regular appointments with one physician who tries to establish a trusting doctor-patient relation, while referrals are limited to strict medical indications<sup>14</sup>. In addition to the above mentioned treatments, which apply to one specific point in the circular process, it is advocated<sup>15</sup> to pay attention to affective psychiatric disorders, and to stress-factors in the patient's life (for instance psychosocial problems, but also somatic diseases), because these can enhance an existing tendency to somatise.



So far it is not clear which treatment for somatisation is the most effective; a recent review of RCTs on treatment for somatisation<sup>16</sup> evaluated CBT interventions only. Neither is it clear which of the treatments can be applied in general practice. A review of RCTs on psychosocial treatments in primary care<sup>17</sup> did not address studies on somatisation. We were especially interested in treatments for somatisation which can be applied by GPs, because GPs are the main care-givers for somatising patients and many somatising patients resist psychosocial or psychiatric referral. Therefore we performed a systematic review of all randomised trials which evaluate effectiveness of any treatment for somatisation, either performed or applicable in general practice. Criteria for applicability in general practice were: a patient population comprising the broad spectrum of somatisation, and a concise intervention which can be taught to GPs and can be applied in a limited number of short sessions.

## **METHODS**

### **STUDY SELECTION**

Sensitive searches were performed in Medline (1966-2000), PsycINFO (1966-2000), and Embase (1979-2000) with search headings “somatoform disorders” or “somatization / somatisation” or “hypochondriasis”, in Medline with the addition “AND therapeutics”. The Cochrane Controlled Trials Register<sup>18</sup> was searched with diagnosis field “somatoform-disorder”. Languages were limited to English, French, Spanish, Italian, German and Dutch. References were checked, related articles were screened, and investigators in the field were contacted for missing publications and unpublished trials. Abstracts or letters were not included. Manually, randomised controlled trials were selected which used any structured measure of somatisation as inclusion criterion, either broad (DSM abridged somatisation, distressed high utilisers, ICD-10 somatisation), or limited to hypochondriasis or somatisation disorder. Studies on isolated functional symptoms or functional somatic syndromes, like chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, non-cardiac chest pain, were not included, since treatments in these studies contained mostly symptom-specific elements which can not be generalised towards the broad spectrum of somatising patients. Studies outside primary care were nor included, unless the intervention seemed applicable in general practice, like pharmacological interventions, or simple psychological interventions. Only studies in which an active treatment was compared with placebo, usual care or a waiting

list condition were admitted; studies comparing two medicines were excluded, since no medicine with proven effectiveness is known. In studies with more than one follow-up measurement, the last follow-up measurement was used, being the most relevant in a long-term problem like somatisation.

#### METHODOLOGICAL QUALITY

Methodological quality of all included studies was assessed using Jadad's scale<sup>19</sup>, which runs from zero to five: each study was scored on adequacy of randomisation, double blinding, and description of drop outs. Studies scoring zero are a priori considered insufficient and hence are not used as a source of evidence. All studies were independently assessed by AHB and JCvK. Raters were not blinded for authors or journals, because AHB was well acquainted with the literature and, moreover, journals and even authors remain recognisable by for instance lay-out and writing style. Consensus was reached in cases of disagreement. Degree of agreement before consensus was expressed in percentage agreement and in kappa.

#### PRESENTATION OF DATA

For each included study data are presented on intervention and control condition, definition of somatisation used for inclusion, setting, age, sex, country, percentage of immigrants, number of patients completing the trial, drop out rate, outcome measures, effect sizes and quality scores.

#### STATISTICS

Effect sizes, with 95% confidence intervals if possible, were calculated of all measures reported by the original authors as main outcome measures. Effect size was defined as change in the intervention group from baseline to follow-up in terms of percentage of the baseline value, minus the change in the control group. We estimated outcomes from figures for studies which presented results only in figures and not in numbers. Since we expected considerable clinical heterogeneity, pooling of effect sizes was not a priori planned.

## RESULTS

### SELECTED TRIALS

The Cochrane database yielded 108 publications on treatment of somatisation, nine of which fulfilled our inclusion criteria. The Medline search yielded 794 publications on treatment of somatisation, from which one additional eligible trial was retrieved, 633 publications resulting from the PsycINFO search yielded two more eligible trials, the Embase search yielded 283 publications, but no extra eligible trial was found. Four additional randomised trials were retrieved by checking references and related articles. Contacts with researchers in the field learned us that four randomised trials with cognitive-behavioural treatment for somatisation are currently being performed: in Denmark (Aarhus, two trials), in The Netherlands (Leiden), and in Spain. None of the current trials could provide results as yet. Unpublished completed trials were not found. Thus 16 eligible trials were retrieved<sup>20-35</sup>, six of which were subsequently excluded, because they did not fulfil inclusion criteria concerning design, patient selection, or analysis of outcome<sup>20-25</sup> (Table 1). With regard to inclusion or exclusion, the assessors AHB and HEvdH disagreed on four items (16 publications, three items per study: agreement 92%). After discussion, consensus was reached about all studies. Finally ten trials were included in the review<sup>26-35</sup>.

Characteristics of the included studies are shown in Table 2, in which the trials<sup>26-35</sup> are indicated by capitals A-J. Four trials recruited patients in general practice [C, D, I, J], in five trials at least part of the patients were from a general practice population [A, B, E, G, H], and in one trial the population from which patients were recruited remained unclear [F]. Interventions were performed by GPs in five trials. Five studies used a broad definition of somatisation as inclusion criterion (C, D, F, H, I), while two studies included patients with the more severe somatisation disorder (A, B), and three studies enrolled patients with hypochondriasis (E, G, J). Different interventions were evaluated, which could be grouped into three categories: psychiatric consultation letter (PCL), drug treatment, and cognitive (behavioural) therapy (C(B)T). PCL was studied in four trials: in three trials [A, B, C] a PCL was sent to GPs, which described the chronic relapsing course of somatoform disorders, advised regular brief appointments with the same doctor each 4-6 weeks, with a brief physical exam at each visit, avoiding unnecessary referrals and diagnostic procedures and avoiding to tell patients that 'it is all in your head'. In a fourth trial [D] findings from a psychiatric diagnostic interview with the patient were discussed with the GP in a joint consultation,

followed by a PCL which contained a therapeutic advice. Two trials studied drug treatment: fluoxetine (an antidepressant of the serotonin reuptake inhibitor type) [E] and opipramol (a sedative with weak anxiolytic and antidepressant effects) [F] respectively. CBT, which focuses on dysfunctional symptom attributions and illness behaviours, was evaluated in two trials [H, I], while explanatory therapy, a simple form of CT focusing on symptom attributions and selective perception of bodily signs, was studied in one trial [J]. A wide variety of outcome measures was used: about thirty different measurement instruments were used, and hardly any instrument was used in more than one study. Authors listed outcomes without indicating which measure was considered as main outcome. Nevertheless, outcomes could grossly be categorised into five groups: psychiatric symptoms were reported in eight

**Table 1** Excluded studies

Study (first author, year)	Interventions	Reasons for exclusion
Speckens '95 <sup>20</sup>	CBT vs usual medical care	Recruitment and intervention outside primary care (general medical outpatient clinic in a university hospital) <u>and</u> intervention not feasible in general practice (from 6 to 16 one-hour sessions)
Avia '96 <sup>21</sup>	CBT vs waiting list	Study not described as randomised
Clark '98 <sup>22</sup>	CBT vs relaxation vs waiting list	Recruitment and intervention outside primary care <u>and</u> interventions not feasible in general practice (up to 16 one-hour sessions)
Bouman '98 <sup>23</sup>	CT vs BT	Two active treatment groups: cognitive therapy vs behavioural exposure therapy, without usual care or waiting list control group.
Hellman '90 <sup>24</sup>	CT vs relaxations vs stress management	Three active treatment groups without usual care or waiting list control group.
Bernal I Cercós '95 <sup>25</sup>	relaxation+anti-depressant vs antidepressant	Both patients with anxiety disorders and patients with somatoform disorders were selected, results for somatising patients were not presented separately. No analysis of outcome in treatment group vs control group (outcome was calculated as contrast between patients compliant versus patients non-compliant with relaxation intervention)

**Table 2** Characteristics of included trials, part one

Study, first author, year	Interventions [N of hours]	Definition of somatisation for inclusion	Patient recruitment setting	Age [mean $\pm$ SD]	%	Country [ethnicity]	Follow-up months	N trial completers	Drop out %	Outcome	Effect size <sup>a</sup> % [95% CI]	Jadad score (0-5)
A. Smith '86 <sup>24</sup>	PCL to GP vs usual GP care	DSM-III $\geq 14$ (& $\geq 12$ (%))	general practice / internists	[45 $\pm$ 13]	16	Arkansas, USA [37% non-whites]	9	38	7	RAND physical health general health mental health social functioning Disability days Savings medical costs	-49 0 -8 -5 10 25	1
B. Rost '94 <sup>25</sup>	PCL to GP vs usual GP care	DSM-III-R $\geq 13$	general practice / advertisement	[44 $\pm$ 9]	15	Arkansas, USA [20% non-whites]	12	70	4	RAND physical health general health mental health social functioning Savings health care costs	18[ 1;35] -1[-10;+8] 5[-5;+15] -2[-13;+9] 21[ -6;32]	1
C. Smith '95 <sup>26</sup>	PCL to GP vs usual GP care	DSM-III-R 6-12	general practice	[43 $\pm$ 12]	25	Arkansas, USA [16% non-whites]	12	56	0	RAND physical health general health mental health social functioning Savings medical costs	23 p.002 -7 p.06 -1 p.33 -10 p.26 33[ 5;53]	2
D. Katon '92 <sup>27</sup>	psychiatric and joint consultations + PCL to GP [1,5] vs usual GP care	N of visits (top 10%) AND SCL-anxiety+depr.>13 OR SCL- somatisation >9 OR referred	general practice	18-75	39	Washington state, USA	12	233	7	SCL depr./ anx./ somatis. Disability Self-reported health status N of health care visits Use of antidepressants	n.s. n.s. n.s. n.s. 38 p<.01	1
E. Fallon '96 <sup>28</sup>	fluoxetine vs placebo at psychiatric outpatient clinic	DSM-IV hypochondria AND illness concern d iary AND unexplained complaints	general practice / advertisement	[44 $\pm$ 11]	33	USA	3	16	20	Clinical Global Impression scale: % much improved	17[-26;60]	3

a. favourable changes are expressed as positive values, unfavourable changes as (-).

**Table 2** Characteristics of included trials, part two

Study, first author, year	Interventions [N of hours]	Definition of somatisation for inclusion	Patient recruitment setting	Age [mean $\pm$ SD]	% %	Country [ethnicity]	Follow-up months	N trial completers	Drop out %	Outcome	Effect size <sup>a</sup> % [95% CI]	Jadad score (0-5)
F. Volz '99 <sup>29</sup>	opipramol capsules 4x50mg dd vs placebo, during 6 weeks, by psychiatrists and other physicians	ICD-10 somatization disorder (F45.0), undifferentiated somatoform disorder (F45.1) or Somatoform autonomic dysfunction (F45.3)	?	18-76	64	Germany	1,5	200	8	Hamilton anxiety scale somatic anxiety psychic anxiety Hamilton depression scale SCL-90-R somatisation subscale anxiety subscale	11 p.013 11 p.013 11 p.052 10 p.006 2 p.041 3 p.043 1 p.049	3
G. Warwick '96 <sup>30</sup>	CBT by psychiatrist vs waiting list [16]	DSM-III-R hypochondriasis	general practice / psychologist / psychiatrist	20-53 [37]	55	UK	4	31	3	global problem rating disease conviction: when anxious when not anxious wanting reassurance: time spent strength of need frequency health worrying time spent health anxiety frequency of checking frequency of avoidance	72 [51;93] 77 [58;96] 135[86;184] 54 [31;77] 63 [37;79] 84 [37;131] 47 [25;69] 42 [23;61] 76 [54;98] 56 [26;86]	2
H. Lidbeck '97 <sup>31</sup>	group-CBT with relaxation by physician at out-patient clinic [8x3] vs waiting list	Kellner FSS <sup>10</sup> (somatisation / hypochondriasis)	general practice and hospital physicians	30-60	16	Sweden	6	49	2	Social Problem Quest. Illness Behaviour Quest. Whitley Index Hypoch. Hosp. Anxi. & Depr. Scale Sleep Disturbance Index Medication	+1 n.s. +15 n.s. +15 p<.01 +3 n.s. -2 n.s. +8 p<.05	1

a. favourable changes are expressed as positive values, unfavourable changes as (-).

**Table 2** Characteristics of included trials, part three

Study, first author, year	Interventions [N of hours]	Definition of somatisation for inclusion	Patient recruitment setting	Age [mean $\pm$ SD]	% %	Country [ethnicity]	Follow-up months	N trial completers	Drop out %	Outcome	Effect size <sup>a</sup> % [95% CI]	Jadad score (0-5)
I. Sumathipala 2000 <sup>32</sup>	CBT by psychiatrist in PC [6x0.5] vs usual GP care	Repeated consultation for $\geq 5$ current medically unexplained complaints	general practice	16-65 [38 $\pm$ 14]	29	Sri Lanka	3	45	34	Complaints GHQ Bradford Somatic Inventory Visits	25 [ 9;40] 43 [ 5;80] 2 [0.4;5] 54[15;90]	3
J. Fava 2000 <sup>33</sup>	Explanatory therapy (CT) by psychiatrist [8x0.5] vs waiting list	DSM-IV hypochondriasis AND illness severity score $\geq 7$ on a 9-point scale	general practice	[30 $\pm$ 8]	20	Italy	6	17	15	Clin. Interview Depression: change hypochondriasis nosophobia thanatophobia bodily preoccupations RatingScale Som.Sympt. Visits to physicians N of laboratory tests IAS: worry about illness concern about pain health habits hypochondriasis thanatophobia nosophobia bodily preoccupations Anxiety Sensitivity Index	32 [22;42] 39 [27;51] 40 [14;66] 45 [26;64] 34 n.s. 30 [10;50] 43 [10;78] 19 n.s. 22 [ 8;36] 18 [ 0;36] 18 n.s. 20 n.s. 20 [ 1-39] 20 n.s. 17 n.s. 41 [12;70]	2

a. favourable changes are expressed as positive values, unfavourable changes as (-).

**Table 3** Quality assessment of included randomised controlled trials, according to Jadad<sup>19</sup>

Criteria	Rating	Identification letter of the study									
		A	B	C	D	E	F	G	H	I	J
1. Was the study described as randomised?	yes: 1, no: 0	1	1	1	1	1	1	1	1	1	1
1a. If yes: was the method to generate the sequence of randomisation described and appropriate?	not described: 0 appropriate: 1 inappropriate: -1	-1	0	0	0	0	0	0	0	1	0
2. Was the study described as double blind?	yes: 1, no: 0	0	0	0	0	1	1	0	0	0	0
2a. If yes: was the method of blinding described and appropriate?	not described: 0 appropriate: 1 inappropriate: -1	-	-	-	-	0	1	-	-	-	-
3. Was there a description of withdrawals and dropouts in each group?	yes: 1, no: 0	1	0	1	0	1	0	1	0	1	1
Sum score		1	1	2	1	3	3	2	1	3	2

studies, somatic symptoms in seven studies, self-reported health in six, health care utilisation in six, and illness attitudes in three studies.

### METHODOLOGICAL QUALITY

The quality score according to the scale of Jadad et al.<sup>19</sup> is shown in Table 3. Degree of agreement between the two assessors before consensus was 91 %, kappa 82%. Consensus was reached about all included trials. Scores ranged from 1 to 3 (median 2). Only the trials with pharmacological interventions [E, F] were described as double blind. Since double blinding is in fact impossible in trials with PCL and CBT interventions, the highest possible score for these trials was three, a level reached by only one study.

### RESULTS FROM TRIALS OF PSYCHIATRIC CONSULTATION LETTERS

Three PCL studies [A, B, C] showed a decrease in medical costs (effect size from 21% to 33%), whereas the fourth study [D] reported no change in the number of health care visits.



Effects on health status were inconsistent and mostly not statistically significant, both in patients with somatisation disorder and in patients with milder degrees of somatisation.

## **RESULTS FROM PHARMACOLOGICAL TRIALS**

The report of the fluoxetine study [E] presented preliminary mid-study results from an ongoing trial on hypochondriac patients. Twenty percents dropped out, and effects were measured in only 16 patients. A modest (17%) clinical improvement was reported, which will have to be re-evaluated after completion of the trial. The opipramol trial [F] showed small effects in 200 somatising patients (effect sizes from 1% to 11%). The follow-up periods did not exceed three months.

## **RESULTS FROM COGNITIVE (BEHAVIOURAL) THERAPY TRIALS**

One trial, in which group CBT was applied by a medical physician to primary care patients with somatisation according to broad criteria [H], showed small favourable effects on somatic and psychiatric symptoms and health care utilisation. Considerable effects were found in two CBT trials, one with patients fulfilling the broad somatisation criteria [I] and one with hypochondriac patients [G], in which individual CBT was applied by psychiatrists. A small trial with explanatory therapy by a psychiatrist for hypochondriac patients from general practice [J] showed considerable effects, which (possibly due to small numbers) did not all reach statistical significance.

## **CONCLUSIONS**

Taken as a whole, this body of ten randomised trials on somatisation is divergent with regard to patient selection procedures, interventions, and outcome measures; even if the same concepts are measured, different instruments are used. This clinical and methodological variation hampers comparison of treatment effects among studies. Follow-up varied from 6 weeks to 12 months, which is rather short, since somatisation is known to wax and wane over years. Methodological quality, as measured by Jadad's 5-item scale, was mediocre in most trials. However, Jadad's scale appeared to be of limited value in our study; a vast majority of the included trials studied interventions for which (double) blinding is a priori impossible, leaving only three items to be assessed. In studies evaluating similar interventions, no relation was found between methodological quality and effect-size.

The present review yields evidence for PCL, which is effective in decreasing health care utilisation without, however, improving symptoms or reported health, which is often impaired in somatising patients. Insufficient evidence is present for effectiveness of drug treatment: many pharmacological trials could not be included into the review, because two active drugs were evaluated without a placebo group. The few placebo controlled pharmacological studies show small effects, which have little clinical relevance. Since the follow-up in the drug trials did not exceed three months, the question remains whether effects are maintained over longer periods, and whether somatising patients are willing to continue the use of medication. CBT shows favourable results, with moderate to considerable effects on physical and psychiatric symptoms as well as on health care utilisation. Our findings are in line with the results of a recent review on CBT, which concludes that CBT can be an effective treatment for somatisation and symptom syndromes<sup>16</sup>. However, the number of trials is small, and methodological quality is mediocre, thus the evidence for effectiveness of CBT for somatisation is limited. No direct evidence is available about effects of CBT performed by general practitioners or practice nurses.

#### RECOMMENDATIONS FOR GENERAL PRACTICE

- a. Basic management strategies which are advised in the PCL studies, can be applied by general practitioners to their most difficult, chronic and relapsing somatising patients: regular brief appointments with the same doctor each 4-6 weeks, with a brief physical exam at each visit, avoiding unnecessary referrals and diagnostic procedures and avoiding to tell patients that 'it is all in your head'.
- b. No evidence based advice for or against drug treatment can be given.
- c. CBT seems a promising approach, but randomised studies of interventions applied by GPs should be awaited before implementation of this treatment in general practice be considered.

#### RECOMMENDATIONS FOR FURTHER RESEARCH

- a. Similar outcome measurements should be used to allow comparison of effects between somatisation studies. These should concern physical and psychiatric symptoms, reported health, health care utilisation and illness attitudes.
- b. A placebo control group is required in pharmacological trials for somatisation, since little evidence is present for effectiveness of any drug.
- c. Randomised studies are needed in which short formats of CBT are applied by general

practitioners, on the broad spectrum of somatising patients including hypochondriac patients.

- d. Randomised trials in which patients are followed for several years will be needed to reveal which interventions for somatisation are really important in achieving improved outcome.

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## Chapter 3

# **Development and feasibility of a modified retribution model for somatising patients, applied by their own general practitioners**

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## **ABSTRACT**

Reattribution has been developed as a cognitive behavioural treatment model for somatisation in general practice. Our objective was to make reattribution suitable for application on patients with longstanding somatisation, including hypochondria, and to evaluate feasibility. Three modifications were developed: (1) dealing with persistent illness worry, (2) adjustment of the doctor's speed to that of the patient, and (3) the use of symptom diaries. Performance of ten experienced GPs, after a 20-hour training programme (six sessions of variable length), was measured by self-registrations and audio-taped consultations. GPs were interviewed on factors interfering with performance. Nine GPs completed the course. Reattribution was applied to 51 out of 75 indicated somatising patients, which required on average three consultations of 10 to 30 minutes' duration. Conclusion: the modified reattribution model offers a feasible approach to the broad spectrum of somatisation seen in general practice; only the modification 'dealing with illness worry' was less feasible.

## INTRODUCTION

Somatisation has been described by Lipowski as ‘a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them’.<sup>1</sup> This definition consists of three elements: (a) the experience of somatic distress, explained by Lipowski as a normal reaction to stressful life events, which only becomes a clinical problem if accompanied by (b) inadequate cognitions (illness attributions) and (c) illness behaviours (seeking medical help). Somatising patients are mostly cared for by their general practitioners (GPs). In general practice, between 10% and 35% of all consultations concern patients who fulfil the criteria of Lipowski’s definition.<sup>2-5</sup> GPs have a need for effective management strategies.<sup>6-8</sup>

Many treatments for somatisation have been advised and studied, varying from psychiatric consultation<sup>9</sup>, psychiatric consultation letters to GPs<sup>10, 11</sup>, and antidepressant medication<sup>12</sup>, to psychological treatments like coping with psychosocial stresses<sup>13</sup>, relaxation exercises<sup>14</sup>, and cognitive behavioural therapy (CBT)<sup>15-17</sup>. Among this wide variety, CBT is repeatedly recommended as treatment of choice.<sup>18-20</sup>

CBT for somatising patients aims at changing the patients’ dysfunctional cognitions and behaviours concerning their somatic symptoms. For somatising patients CBT has several advantages<sup>21</sup>: it is readily understandable by both patients and doctors, it addresses the physical complaints which the patient presents, it requires limited time, and moreover, it has received experimental support. Randomised controlled trials,<sup>15, 16, 22</sup> have demonstrated the effectiveness of CBT in reducing health care utilisation, decreasing hypochondriac worries, and increasing subjective health, in somatising patients referred to a hospital. A disadvantage of these extensive forms of CBT is, that patients have to be referred.

The ‘retribution model’ has been developed as a concise CBT for somatisation, which can be applied by trained GPs, during surgery hours.<sup>23, 24</sup> Reattribution stimulates patients to move from a purely physical view on the cause of their somatic symptoms, towards a broader view in which psychosocial explanations are considered as well. As shown in Table 1, the retribution model has three stages: (1) exploration of the patient’s problems, to make the patient feel understood, (2) broadening the agenda, which is focused on somatic complaints, to psychosocial issues, and (3) making a link between the patient’s distress and the physical complaints. With an eight hour training programme, reattribution can be taught both to experienced GPs<sup>25</sup> and to GP-trainees<sup>23</sup>. Recent research has shown that training experienced GPs to apply the retribution model is cost-effective: referrals and health care



contacts outside primary care decreased.<sup>26</sup> Psychiatric symptoms improved only in ‘part somatisers’, who can accept emotional causes for their symptoms. ‘True somatisers’, who stick more firmly to their somatic attributions, did not improve. This reflects a limitation of the reattribution model, which has already been brought up by the original authors<sup>23</sup>:

Reattribution is designed to be applied early (preferably within six months) in the process of somatisation, since it is postulated that the longer the somatisation continues, the more patients become ‘true somatisers’.

In the present study the reattribution model was adapted to fit the broad spectrum of somatising patients in general practice, including patients with longstanding somatisation and hypochondriac patients. Effects on patient level were evaluated in a randomised controlled trial, which is reported elsewhere.<sup>27</sup> This paper addresses the following research question: is application of the modified reattribution model by the patient’s own GP feasible?

## **METHODS**

### **DEVELOPMENT OF A MODIFIED REATTRIBUTION MODEL**

Modifications to the reattribution model were developed in order to make reattribution suitable for patients with longstanding somatisation, including hypochondriac somatisers. Apart from these modifications, the original reattribution model was applied integrally. (see Table 1)

Our first modification, ‘dealing with persistent illness worry’, is a cognitive-behavioural intervention, developed by Salkovskis, which precedes the first stage of reattribution in somatising patients with hypochondriac illness worries. These patients keep asking for reassurance, which, however, enhances their dependency on doctors, and leaves them without skills to reassure themselves.<sup>28</sup> The GP explicitly stops reassuring and shifts to one (or more) out of three alternative approaches to address the illness worries. The GP may (a) challenge the patient to explore the most alarming thought about the symptoms, to assess the chance that this most alarming thought will become true, and to consider other, less alarming, explanations. If the patient fears a circumscribed disease and keeps requesting diagnostic tests, GP and patient may (b) negotiate about a valid final test, ordered not for medical reasons, but to enable the patient to stop worrying. If the patient avoids situations that provoke illness worry, (c) gradual exposure to threatening thoughts and activities may diminish disease anxiety, analogous to CBT for anxiety disorders.

The second modification is ‘adjusting the doctor’s speed to that of the patient’. In comparison with the original reattribution model, our training programme puts more emphasis on the doctor not going faster than the patient. In order to stimulate even ‘true somatisers’ to explore links between emotions/life events and symptoms, GPs should withhold their own interpretations, at least until the end of the second stage of reattribution. This has an additional advantage of enhancing the, widely advocated, patient-centredness of the reattribution model.<sup>29-32</sup>

The third modification is the use of a symptom diary. Symptom diaries stimulate active participation of the patient, and have been recommended in guidelines for the treatment of somatisation<sup>19, 33</sup>. After a first exploration of the complaints, followed by a focused physical examination, the patient is asked to keep a symptom diary. On a three-column sheet the patient notes (a) severity of symptoms, (b) activities, and (c) thoughts, worries and feelings regarding the symptoms. The symptom diary supports the three stages of reattribution. Firstly, by proposing a diary and offering a follow-up consultation, the GP takes the patient’s problem seriously. Secondly, the registration of symptoms, activities, thoughts and feelings stimulates the patient to think about attributions and feelings in the weeks between the consultations, and broadens the agenda without forcing the patient to switch from a somatic to a psychosocial attribution too quickly. Thirdly, the diary offers material for making a link. Two weeks later the results of the symptom diary are discussed. The GP shows appreciation for the patient’s work, asks for explanation, and gives the floor to the patient, asking for the patient’s observations and comments on the content of the diary. Afterwards the GP can tentatively add his/her own interpretations. If the patient does not see or accept a link, the GP should avoid imposing his/her own ideas about possible links upon the patient. The GP should conclude that although no acceptable link has emerged, the diary has nevertheless provided useful information about the pattern of complaints. A repeated period of diary keeping during a next episode of somatic symptoms might yield new conclusions.

## THE GP TRAINING PROGRAMME

Ten GPs from eight practices were enrolled into the training group. They had been working in their present practices for at least five years, were interested to participate in the study, but had not attended specific courses on treatment of somatising patients and were not acquainted with the reattribution model. A training programme of 20 hours duration was developed. In two five-hour sessions, with two of the authors (AHB and DdV) as session leaders, the GPs were trained to apply the modified reattribution model: each component part

was demonstrated live, followed by role-play. The first session dealt with the first, second and third stage of reattribution, while the second session focused on persistent illness worries. The GPs were instructed to apply the reattribution model whenever an assigned somatising patient would present complaints that were insufficiently accounted for by pathological findings. Reattribution could be started immediately or in an extra consultation at a more convenient moment. The steps of reattribution could be spread over several consultations. In four follow-up sessions of two hours each, problems encountered by GPs while applying reattribution in practice received special attention, and deficiencies were trained again by role-play. Again, dealing with persistent illness worry required as much time as the three stages of reattribution. Between the sessions the GPs were twice offered individual feedback on audio- or videotaped consultations (counted as one training hour each).

Several components of the modified reattribution model required special attention during the training sessions (see Table 1, fourth column). Concerning persistent illness worry, GPs hesitated to stop reassurance. GPs were stimulated to recognise that reassurance falsely comforts both doctor and patient, and to create a personal vocabulary to tell a patient explicitly that they had decided to stop reassuring. Discussing a final test, exploring alarming thoughts and stimulating exposure were new techniques, which GPs found difficult to perform: these techniques had to be practised by role-play repeatedly. Concerning the first stage of reattribution, feeling understood, the GPs were reluctant to ask detailed questions about the physical complaints of somatising patients, and tended to shift to open questions about the patient's views and worries. Another point for attention was the use of symptom diaries. Discussion revealed three sources of resistance: GPs doubted if somatising patients would co-operate, they felt unable to instruct the patient, or they expected difficulties when discussing the results with the patient. By role-playing the GPs learned to motivate patients by presenting the diary as an additional diagnostic tool, to avoid speculating about possible results, to give clear instructions and to structure the discussion in the next consultation.

## EVALUATION OF FEASIBILITY

Feasibility was studied in the context of a trial, in which practices were randomised to provide reattribution versus usual GP care. Ten GPs were randomised to provide reattribution. Patients aged 20 to 45 were included in the trial if they had visited their GP at least 15 times over the previous three years (which represents the upper 8% of this age group in the Netherlands), and had five or more somatisation symptoms (lifetime) on the DSM-III-R somatisation scale<sup>34, 35</sup>.

To assess the feasibility of the modified reattribution model, actual performance of the reattribution skills in daily practice<sup>36</sup> was measured during one year, both by registration forms, on which the GPs noted which reattribution stages had been performed, and by audio-taped consultations (three from each GP). The percentage of indicated patients in which GPs started reattribution was calculated. To evaluate whether GPs started reattribution with the most severe somatisers as well, patients who fulfilled the criteria of somatisation disorder ( $\geq 13$  DSM-III-R symptoms) were analysed separately, as were patients who were judged by their GP as 'very difficult patient' (5-point Likert scale from 0 = not difficult to 4 = very difficult). The Health Anxiety dimension of the Illness Attribute Scales<sup>37, 38</sup> was measured, to assess if GPs applied 'dealing with persistent illness worries' to those patients who showed high levels of health anxiety (above the 50th percentile of the study population). GPs were interviewed two years after the start of the course, on their appreciation of the reattribution model and on factors impeding performance in practice. GPs' time investment, a possible impeding factor for implementation, was estimated from the duration of the training programme, the duration of taped reattribution consultations, and the number of reattribution consultations.

## RESULTS

All ten GPs completed the first two training sessions, and practised the components of the modified reattribution model in role-play. Nine GPs completed the full course; one GP started intervention with only three patients out of 10, reported not seeing an indication in five patients, and stopped attending the course after the first follow-up session. Registration forms of all consultations with assigned patients during one year were returned. In spite of repeated requests, only seven GPs returned a total of 15 audio-tapes (15 different patients). GPs who did not return audio-tapes, reported that they felt uneasy about recording consultations; several GPs had never taped any consultation before.

GPs did not start intervention in 24 out of 75 included patients, for which they reported the following reasons: patient does not somatise by now (6x), actual symptoms cannot easily be reattributed (4x), interference with psychiatric therapy (2x), language barrier (1x), patient makes erotic advances (1x), patient moved to another GP (4x), no reason (6x). As can be seen from Table 2, GPs actually applied reattribution to 51 patients, with a median of three reattribution consultations per patient (inter-quartile range 2-5). Reattribution was

**Table 1** Modified reattribution model<sup>a</sup>

When to apply	Stage of reattribution	Action	Emphasis in GP-training sessions
In hypochondriac somatisation	STAGE 0: dealing with persistent illness worry	1. Stop reassurance	If repeated reassurance does not help: stop explicitly
		2a. Challenge most alarming thought	
		2b. Negotiate about final diagnostic test	Apply if patient keeps asking for tests/referrals, do not underbid
		2c. Exposure	Apply if patient shows avoidance behaviour
First reattribution consultation	STAGE 1: feeling understood	1. Take a history of symptoms	Listen attentively for 5 minutes
		2. Be alert on emotional cues, social and family factors and health beliefs	Summarise physical, emotional and cognitive aspects, without suggesting a link
		3. Carry out a focused physical examination	Examine attentively and explain what you are doing
Second reattribution consultation	STAGE 2: broadening the agenda	1. Feed back the results of the examination	Summarise normal finding in positive terms, avoid to label symptoms as signs of disease
		2. Acknowledge the reality of symptoms	
		3. Introduce symptom diary	Why, what, how and when to register, avoid speculating on results
		4. Use the diary to reframe the complaints: Link physical, psychological and life events	Stimulate the patient to look for links, suggesting a link is allowed now, stop when the patient rejects your link
	STAGE 3: making the link	1. Simple explanation	Discuss how distress, depression or anxiety give rise to physiological changes, which produce somatic symptoms
		2. Demonstration	

a. Elements derived from the original reattribution model of Goldberg and Gask<sup>23,24</sup> are presented in *Italics*

**Table 2** Reported application of the modified reattribution model to potentially 75 somatising patients by 10 general practitioners<sup>a</sup>

Stages of modified reattribution		Applied to N of indicated patients (overall percentage, inter-GP range)
Modified Reattribution <sup>b</sup> :		51 (68%, 30%-100%)
Stage 0	Dealing with persistent illness worry	15 (20%, 0%-30%)
	stop reassurance <sup>c</sup>	13
	final test <sup>c</sup>	3
	alarming thought <sup>c</sup>	3
	exposure <sup>c</sup>	1
Stage 1	Feeling understood	47 (63%, 30%-100%)
Stage 2	Broadening the agenda	37 (49%, 20%-60%)
Stage 3	Making the link	33 (44%, 30%-100%)
	with psychosocial factor	23
	with depression	8
	with anxiety disorder	2

a. Two pairs of GPs working part-time, in shared practices, were considered as 'one practice' per duet, resulting in eight practices

b. At least one stage of modified reattribution is applied

c. Combinations of different techniques are allowed

started with six out of ten patients with somatisation disorder. With somatising patients who were judged as very difficult, GPs started reattribution less often (five out of 11 patients). The third stage of reattribution was achieved in 33 patients: 23 patients linked their somatic symptoms to psychosocial stress factors, eight patients made a link with anxiety and two with depression. Three patients did not show up on a follow-up consultation or 'escaped' to another doctor, after they were instructed to keep a symptom diary. 'Dealing with persistent illness worry' was applied to 15 patients, 13 of whom had an IAS health anxiety score above the 50th percentile of the study population.

The mean duration of the 15 audio-taped reattribution consultations was 16 minutes (range 10-30). A stimulating, patient-centred approach was recognised in all taped consultations. In consultations where GPs summarised findings without adding their own interpretations, patients tended to reattribute more easily. Instructions for keeping a diary

were given clearly, but several GPs added speculations about possible results. Because of the small number of returned tapes, no quantitative analyses are reported.

In interviews, two years after the start of the course, GPs reported that the reattribution techniques had become 'a useful addition to their repertoire' which, however, had not solved somatisation: patients remained frequent attenders, and with new symptoms GPs had to start reattribution again. All ten GPs (including the one who had dropped out) reported that they used reattribution, mostly during their normal surgery hours, although some GPs preferred to make separate appointments. All GPs still suggested the use of diaries to somatising patients. The techniques for dealing with persistent illness worry were evaluated as useful, but difficult to perform, as they deviated from the GPs' normal working style. Stopping reassurance evoked feelings of uncertainty, some GPs did not feel competent to challenge alarming thoughts. Most GPs reported that skills tended to fade away after the end of the course. Peer group meetings were suggested to brush up the skills periodically. The time expenditure was acceptable for all GPs.

GPs time investment consisted of 20 hours for learning reattribution, and about 50 minutes (three reattribution consultations, with an estimated duration of 16 minutes) for each patient to whom reattribution was applied.

## DISCUSSION

Our findings confirm the results of previous studies, in which reattribution appeared to be a feasible short form of CBT for somatisation in general practice<sup>24,25,39</sup>: GPs can be trained to perform reattribution, and they do apply the new skills in daily practice. With 70 % of the patients intervention was started, and over 50% of all patients made a link between their physical complaints and psychosocial factors, affective disorders, and/or persistent illness worries. Taking into account that patients were selected by objective criteria, and were assigned to the intervention without involvement of their GP, these percentages indicate a fairly good feasibility.

A problem, concerning the first stage of the reattribution model ('feeling understood'), might be specific for Dutch GPs: the GPs were surprisingly reluctant to ask specific complaint related medical questions, in somatising patients. An explanation could be that, since 1975, Dutch GPs have been educated to start the consultation with an intake, in which the patient's questions and worries are explored<sup>29, 40</sup>, whereas inquiring a specific complaint related

medical history at the start of the consultation is considered to enhance somatic fixation<sup>41, 42</sup>. This differs from the reattribution model, in which a full history of the main complaint is taken early in the consultation, in order to make the patient feel understood, as a prerequisite to the broadening of the agenda.

Two of our modifications, 'adjusting the doctor's speed', and 'the symptom diary', were easily adopted by our GPs. The fear that symptom diaries might deter patients from contacting their doctor, is not confirmed in this study: only three patients stayed away from a follow-up appointment after a symptom diary had been proposed. The modification 'dealing with persistent illness worry', appeared to be less feasible: it was applied to only 15 patients, whereas it is known that over one third of somatisers reports hypochondriac fears<sup>43</sup>. This may be explained by the finding, that some GPs did not feel competent to apply this part of the intervention, and felt a need for more extensive training on this item.

Learning and applying the modified reattribution model requires time: our GPs spent 20 hours on training and feedback sessions (10 hours on reattribution stage one to three, and 10 hours on dealing with persistent illness worries); application of the model during one year required about 50 minutes per patient on average. This time investment might be partly outweighed by a decrease in non-reattribution consultations: Morriss reported a decrease of 10% in the number of primary care visits during three months after training GPs.<sup>39</sup> In our study the mean duration of audio-taped reattribution consultations was 16 minutes (no data were available on duration of consultations which were not audio-taped). Although we cannot compare this with the duration of non-reattribution consultation of somatising patients, it truly is longer than the average consultation in Dutch general practice. Our GPs accepted considerable time investment, but as participants in a trial they were probably more interested in somatisation than the average GP. The question arises whether it is realistic to offer the modified reattribution model as a regular postgraduate course for GPs. It can be argued, that psychological interventions which require extensive training and continuing education, and longer consultations than the average 10 minutes, are beyond the scope of GPs, and should be performed by other primary care workers, especially when GPs are not beforehand willing to offer a psychological approach<sup>44</sup>. A major argument, however, favours application of short forms of CBT, like reattribution, by GPs: somatising patients present their symptoms mostly to their GPs, so GPs need an effective approach to avoid reinforcing abnormal illness behaviour, even if a patient is or will be referred. Investing considerable time in a training course may thus be acceptable if reattribution would prove to be effective, since somatisation is a both frequent and difficult problem for GPs. It may be worthwhile to train GPs to apply



this form of CBT, the more since there is growing evidence for the effectiveness of other forms of CBT not only for somatisation, but also for other highly prevalent patient problems in general practice, like depression and chronic fatigue<sup>45, 46</sup>.

A more fundamental question is, if reattribution is really desirable for somatising patients. Early studies on attributions showed that, in women with breast cancer, no particular attribution was found to be tied to good psychological functioning; attributing the cancer to stress was even associated with worse adaptation<sup>47</sup>. Nevertheless, psychologists stressed the importance of individuals seeking their own labels for their symptoms, in order to diminish the threat aroused by the symptoms.<sup>48</sup> Tuckett found that doctors could help patients to make sense of biomedical information, subject to discussion of the patients' interpretations.<sup>49</sup> In conclusion, reattribution might be desirable for somatising patients, not in order to turn 'somatisers' into 'psychologists', but rather to stimulate interaction between patient and doctor about the interpretation of symptoms.

A limitation of this study is that performance of reattribution in practice was measured mainly by self-registration forms. The number of audio-tapes returned was disappointingly low; recording consultations on tape appeared to be more threatening than we had expected. Although all forms which could be compared with audio-tapes, showed good correspondence between the two measures, GPs might have flattered their performance in unchecked registration forms, which would have resulted in an overestimation of feasibility. However, taking into account the frankness with which GPs brought their problems forward in the training sessions, we have no reason to suspect biased registrations. Another limitation is the small number of GPs. Between the 10 GPs a wide variation in performance of reattribution was found, but exploration of determinants of the inter-doctor variation was beyond the scope of this study. Further study on determinants of the inter-doctor variation in performance would help us to tailor the training programme to each GP. Moreover, it would help individual GPs to decide whether learning and applying reattribution will be feasible for them. When the modified reattribution model is offered to GPs as a postgraduate course, systematic evaluations should address the feasibility in daily practice, especially of the modification 'dealing with persistent illness worry'.

## IMPLICATIONS FOR GENERAL PRACTICE

The modified reattribution model can be taught to GPs in a 20-hour training programme (10 hours of which are spent on persistent illness worries). Application to somatising patients (spread over several consultations), requires on average 50 minutes per

patient. Dealing with persistent illness worry is more difficult to perform than the other stages of the modified reattribution model. Alternatively, a model of stepped care might be introduced, in which GPs would receive a ten-hour course to apply reattribution to somatising patients, while those patients whose persistent illness worries require a specific approach are referred to specialised mental health care workers.

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## Chapter 4

### **Effectiveness of reattribution for somatisation in general practice, a randomised controlled trial**

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## ABSTRACT

**Objective** To evaluate effectiveness of reattribution, a concise cognitive behavioural approach, applied by trained GPs to their own somatising patients.

**Methods** A randomised controlled trial was performed in 17 general practices. with final assessment at 24 months after the baseline assessment. Patients aged 20 to 45 were selected, who had visited their GP at least 5 times a year during three years, with five or more lifetime somatisation symptoms (DSM-III-R). Practices were randomised to usual care versus reattribution intervention. Seventy percents of eligible patients gave informed consent. Seventy-five intervention patients and 87 controls entered the trial, 68 intervention patients and 81 controls completed the trial. Main outcome measures were Subjective health, medical consumption, and sick leave.

**Results** The reattribution group improved significantly, compared to the usual care group which remained unchanged, on all three outcome measures. Effects were more marked at 24 months than at 12 months. Subjective health increased from median 36/100 to 74/100. Medical consumption decreased: the number of health care visits per 6 months decreased from median 10 to 5, while the number of medicines used remained unchanged. Sick leave diminished from median 5 to 0 weeks per 6 months.

**Conclusions** Reattribution offers an effective approach to the broad spectrum of somatisation, seen by GPs. Effectiveness in older patients and immigrants remains to be studied.

## INTRODUCTION

Somatisation, described by Lipowski<sup>1</sup> as ‘a tendency to experience and communicate somatic distress and symptoms, unaccounted for by pathological findings, to attribute them to physical illness and to seek medical help for them’, is a major problem in medical care. In general practice, between 10% and 35% of all consultations concern patients whose illness behaviours fulfil the criteria of Lipowski’s definition<sup>2,3</sup>: in these patients somatisation affects subjective health and gives rise to increased health care utilisation.<sup>4,5</sup> General practitioners (GPs) often describe somatising patients as difficult<sup>6,7</sup>, and they report a need for effective therapeutic strategies<sup>8</sup>. Cognitive Behavioural Therapy (CBT) is widely recommended as treatment of choice for somatisation.<sup>9-11</sup> There is growing evidence that CBT, applied by psychiatrists, improves subjective health and decreases health care utilisation in somatising patients<sup>12,13</sup>, including hypochondriac somatisers<sup>14</sup>. A concise CBT for somatisation, which has been developed for application by general practitioners (GPs), is the reattribution model<sup>15,16</sup>, which stimulates somatising patients to link medically unexplained physical symptoms to other causes than somatic disease (see Table 1). Recent research<sup>17</sup> has shown that training GPs to apply reattribution is cost-effective: health care utilisation outside primary care decreases, while psychiatric symptoms improve. A limitation of the reattribution model is, that it is designed to be applied early in the process of somatisation<sup>15</sup>, when patients are assumed to accept emotional causes for their symptoms (‘part somatisers’) more readily than in longstanding somatisation (‘true somatisers’). GPs, however, see many patients with longstanding somatisation. In the present study the reattribution model was made suitable for patients with longstanding somatisation and hypochondriac patients. A randomised controlled trial was performed, in which the main research question was: is reattribution, applied by the patient’s own GP, more effective than usual care in improving subjective health, reducing medical consumption, and decreasing sick leave, in patients who have been somatising for at least three years in general practice?

## METHODS

A non-blinded randomised controlled trial was performed in 17 general practices in the Netherlands. The trial was part of a twin study with identical patient selection and randomisation procedures, with shared control practices. Twelve practices in the region of



Amsterdam were randomly assigned as intervention (8 practices) versus control practices (4), and five control practices from the sister trial in the region of Maastricht<sup>18</sup> were added. GPs in intervention practices attended a 20-hour training programme to apply reattribution, including feedback on audio-taped consultations and booster sessions during the first follow-up year. Patients were followed during two years. The protocol was approved by the Ethics Committee of the Academic Hospital of the Vrije Universiteit Amsterdam.

## RECRUITMENT OF PRACTICES

In the region of Amsterdam, GPs were recruited who had not attended courses on somatisation or CBT, and had been working in their present practices for at least five years. Nineteen GPs were contacted, of whom 15 participated (from 12 practices). From the Maastricht sister trial, in which practices were recruited from the Registration Network of General Practices<sup>19</sup>, five control practices (with five GPs) were added.

## RECRUITMENT OF PATIENTS

Records of patients aged 20 to 45, with at least 15 visits to GPs on the patients' initiative in the previous three years (representing the 10% most frequently attending patients in this age group in the Netherlands<sup>20</sup>), were retrieved from practice records. In these frequent attenders, somatisation was assessed by a postal questionnaire, developed by the authors and validated in a pilot study, which inquired after the lifetime occurrence of 37 somatisation symptoms listed in the DSM-III-R<sup>21</sup>. Symptoms counted if, according to the patient, doctors had not explained them by organic disease, use of medicines, alcohol or drugs.<sup>22</sup> Patients with five or more symptoms were invited to participate in the trial. Exclusion criteria were assessed by the GP: insufficient knowledge of the Dutch language, and serious diseases which would probably interfere with the reattribution intervention, like cancer or psychosis. Patients with other chronic diseases, with depression or with anxiety disorders were not excluded, in order to maintain generalisability for somatising patients in primary care. A research assistant asked eligible patients for informed consent, before randomisation of practices. In order to keep the intervention feasible for the GPs, a maximum of 10 patients per intervention practice were randomly admitted to receive the reattribution intervention.

## STRATIFIED RANDOMISATION OF PRACTICES

To control for contamination, randomisation was performed on practice level. Twelve practices were divided into homogeneous triads, matched by aspects known to influence GP

consultation style: sex of the GPs, single-handed versus shared practice, and urban versus (semi)-rural population. By drawing lots sealed in identical opaque envelopes, two practices from each triad were allocated to the intervention condition, while the third was allocated to the control condition. Five control practices were added from the sister trial, in which an identical randomisation procedure had been performed. Randomisation was performed by an independent person, who was involved neither in the organisation of the trial, nor in the execution of the intervention.

### TREATMENT CONDITIONS

In the control condition, patients received medical care as usual. Patients randomised to the intervention condition received medical care as usual plus the reattribution intervention, applied by their GPs during normal surgery hours. Reattribution was started as soon as an intervention patient visited the GP with unexplained complaints. Reattribution consisted of the model developed by Goldberg and Gask<sup>15,16</sup>, to which three modifications had been added, as is shown in Table 1. The first addition is a cognitive behavioural approach to hypochondria, developed by Salkovskis<sup>23</sup>: if repeated reassurance does not help, the doctor explicitly stops reassuring and explores the patient's most alarming thought, negotiates about a final diagnostic test which enables the patient to stop worrying, or uses graded exposure to situations which provoke illness worry. A second modification concerns the GP's consultation style: while stimulating the patient to explore links between symptoms and psychosocial factors, the GP withholds his/her own links until stage three. A final modification is the use of diaries, in which the patient notes symptoms, activities and all thoughts, worries and feelings regarding the symptoms.<sup>24</sup> The reattribution intervention is tailored, which implies that not all elements need to be applied to all patients.

### MEASURES

At baseline, one year, and two years after entry in the trial, patients completed questionnaires on outcome measures. (1) Medical consumption, calculated over the last six months, consisted of (a) the number of visits to all health care workers including GPs, and (b) the number of different medicines used for at least one week. (2) Subjective health was measured over the previous month, as the combined score on (a) the mean of six visual analogue scales on the influence of actual symptoms on work, sleep, sport/exercise, social life, mood, ruminating about symptoms, and (b) a direct question on health (visual analogue scale). (3) Sick leave was defined as absence from work or household by illness, expressed in

weeks during the last six months. As a subsidiary outcome, symptoms of somatisation were measured with the validated somatisation sub-scale of the Symptom Check List (SCL)<sup>25</sup>.

Social stresses were measured as the number of life events last year, and chronic difficulties<sup>26</sup>. Social support, a known protector against stresses, was the average support received from the five most important persons in the patient's life: mean of seven 4-point questions plus one VAS scale. Support from the GP was measured similarly. As possible effect modifiers, symptoms of depression, and anxiety plus agoraphobia were measured with the respective SCL sub-scales; hypochondria was measured as the health anxiety dimension of the Illness Attitude Scales<sup>27,28</sup>. Questions on childhood problems were derived from an earlier study<sup>29</sup>. GP-judgements on somatisation and on difficulty of the patient were measured with 5-point Likert scales, dichotomised into 1-2=no and 3-5=yes.

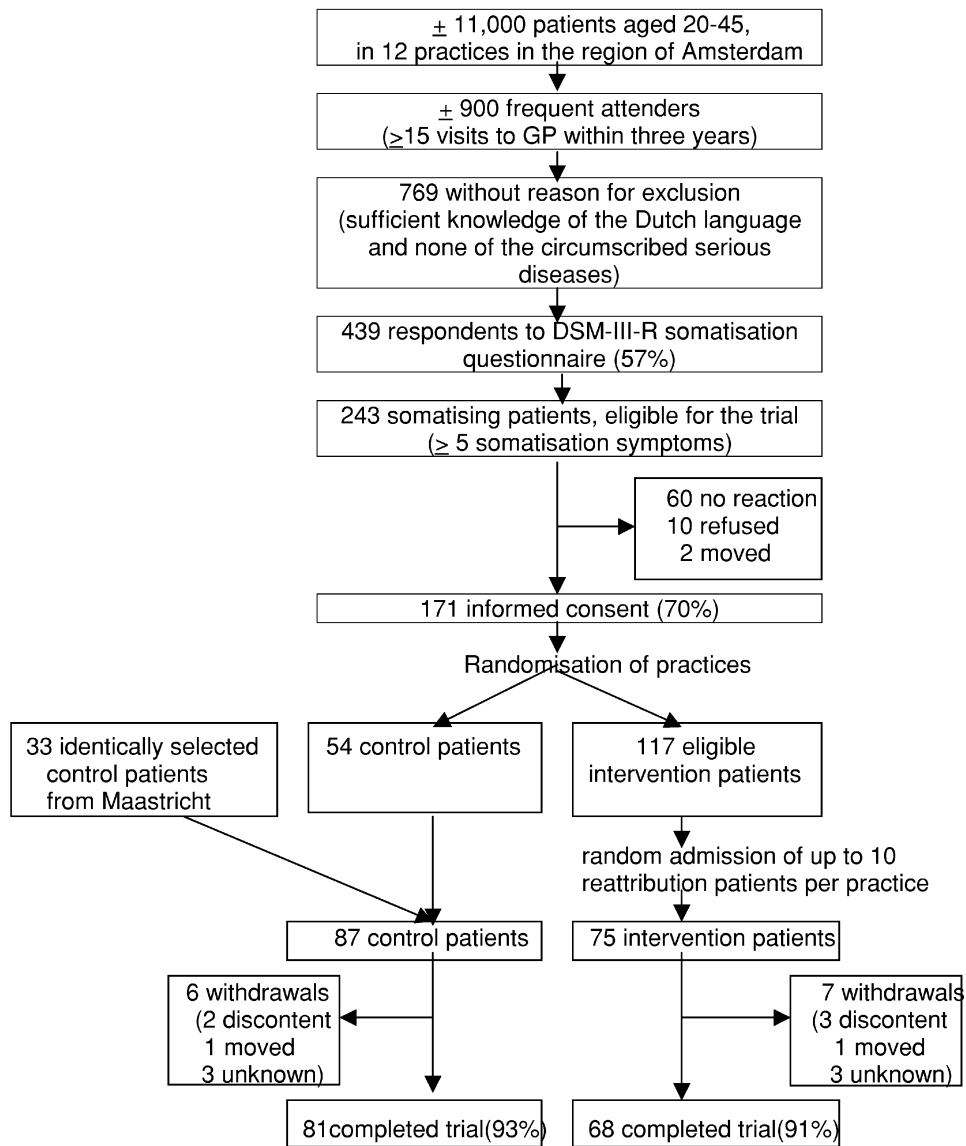
For each consultation with an intervention patient, GPs noted on a tick-on form which reattribution stages had been performed. If no intervention had taken place, the reason was noted. The number of visits to GPs during the two-year follow-up was retrieved from practice records.

## STATISTICAL ANALYSIS

To detect a minimum relevant difference of 25% between intervention and control condition on the main outcome measure medical consumption, with a two-sided alpha of 5% and beta of 10%, 60 patients per group had to complete the trial. To allow up to 25% withdrawals, a sample size of 80 patients per group was required. Analyses were based on intention to treat. Effectiveness of the intervention was expressed as the difference in change between the treatment groups (Mann-Whitney U test, two-sided  $p < .05$ ) in the main outcome measures from baseline to 24 months follow-up. Effects of change in social stresses were detected by testing differences between treatment groups, and entered into a multiple regression model. Possible effect modifiers were detected by subgroup analyses, followed by multiple regression analysis of detected modifiers. To estimate the distribution of treatment effects over intervention versus control practices, practices were ranked according to descending effect size (mean change in subjective health). In the intervention group Kruskal-Wallis tests were performed to test the influence of the factor 'practice' on the outcome variables. For the reattribution group, Spearman rank correlation coefficients were calculated between starting versus non-starting of the intervention, and support from GP, GPs' judgement on somatisation and difficulty of the patient.

## TRIAL PROFILE

Progress of patients throughout the trial is shown in Figure 1. Response rate of frequent attenders to the somatisation questionnaire was 57%, non-responders relatively often were immigrants with a mediocre knowledge of the Dutch language. Informed consent was



**Figure 1** Trial profile

given by 70% of eligible patients, non-participants relatively often were singles or immigrants. After randomisation of practices, eight intervention practices appeared to provide 117 patients, of whom a maximum of 10 patients per practice were randomly admitted to the trial, resulting in 75 intervention patients. The remaining 42 patients, who received usual care within an intervention practice, were followed outside the trial, which allowed us to study whether non-intervention patients benefit as well from the reattribution skills of trained GPs. Four control practices yielded 54 patients for the usual care condition, which was enlarged with 33 patients from the sister-trial. The trial started in January 1997 with 75 patients in the intervention group and 87 patients in the usual care group. During two-year follow-up, 12 patients dropped out (7%). Reasons for withdrawal did not differ between treatment groups. At baseline the treatment groups were quite similar: none of the variables showed a significant ( $p < .05$ ) difference.

## RESULTS

GPs started the reattribution intervention, during the first year of the trial, with 51 of the 75 intervention patients. Complete reattribution was achieved in 33 patients: 23 patients linked their somatic symptoms to psychosocial stress factors, 8 patients made a link with anxiety and 2 with depression. Dealing with persistent illness worry was applied to 15 patients, 13 of whom had an IAS health anxiety score above the 50th percentile of the trial population. GPs did not start intervention in 24 patients, for which they reported the following reasons: patient does not somatise by now (6x), actual symptoms cannot easily be reattributed (4x), interference with psychiatric therapy (2x), language barrier (1x), patient makes erotic advances (1x), patient moved to another GP (4x), no reason (6x). GP's decision to start intervention was hardly correlated with support from the GP at baseline (Spearman coefficient .205;  $p$ -value .095), with GP's judgements on somatisation (.138; .238) or on difficulty of the patient (.167; .152). Only in patients who were judged as very difficult (5 on a 1-5 Likert scale), GPs started intervention less often (five out of 11 patients). Response to treatment at 12 and 24 months follow-up is shown in Table 3. From baseline to the final 24 month assessment, the intervention group showed significant favourable changes compared to the usual care group, on all three main outcome measures. Medical consumption decreased in the intervention group: the number of health care visits was halved, due to a lower percentage of

**Table 1** Modified reattribution model<sup>a</sup>

When to apply	Stage of reattribution	Action
In hypochondriac somatisation	STAGE 0: dealing with persistent illness worry	<ol style="list-style-type: none"> <li>1. Stop reassurance</li> <li>2a. Challenge most alarming thought</li> <li>2b. Negotiate about final diagnostic test</li> <li>2c. Exposure</li> </ol>
First reattribution consultation	STAGE 1: <i>feeling understood</i>	<ol style="list-style-type: none"> <li>1. <i>Take a history of symptoms</i></li> <li>2. <i>Be alert on emotional cues, social and family factors and health beliefs</i></li> <li>3. <i>Carry out a focused physical examination</i></li> </ol>
Second reattribution consultation	STAGE 2: <i>broadening the agenda</i>	<ol style="list-style-type: none"> <li>1. <i>Feed back the results of the examination</i></li> <li>2. <i>Acknowledge the reality of symptoms</i></li> <li>3. Introduce symptom diary</li> <li>4. Use the diary to <i>reframe the complaints: link physical, psychological and life events</i></li> </ol>
	STAGE 3: <i>making the link</i>	<ol style="list-style-type: none"> <li>1. <i>Simple explanation</i></li> <li>2. <i>Demonstration</i></li> </ol>

a. Elements derived from the original reattribution model of Goldberg and Gask<sup>15,16</sup> are presented in *italics*

**Table 2** Comparison of both treatment groups at baseline. N=162<sup>a</sup>

	Scale range	<b>Reattribution</b> N=75 median or percentage (inter-quartile range)	<b>Usual care</b> N=87 median or percentage (inter-quartile range)
<b>Socio-demographic characteristics</b>			
Age in years	20-45	36 (29-41)	36 (31-41)
Female sex		85%	86%
Married or cohabiting		64%	67%
Educational status: low		37%	41%
middle		43%	46%
high		20%	13%
Professional status: low		70%	64%
middle		15%	32%
high		15%	5%
Paying job		49%	52%
Immigrant status		16%	16%
<b>Inclusion variables</b>			
N of visits to GP/year (mean of previous 3 years)	≥5	7.0 (5.3-8.7)	6.7 (5.7-8.3)
Lifetime somatisation symptoms DSM-III-R	5-37	7 (6-10)	7 (5-9)
Gastrointestinal	0-5	2 (1-3)	1 (0-2)
Pain	0-4	1 (1-2)	1 (0-2)
Cardiopulmonary	0-4	2 (1-3)	1 (1-2)
Neurologic	0-7	1 (1-2)	1 (0-1)
genito-urinary	0-7	1 (0-2)	1 (0-2)
<b>Main outcome measures</b>			
Medical consumption (preceding 6 months)			
N of health care visits		10 (4-23)	12 (7-24)
N of different medicines		4 (3-5)	4 (3-5)
Subjective health (last month)	0-100	36 (26-50)	36 (19-54)
Sick leave in weeks (preceding 6 months)	0-26	5 (3-13)	4 (1-10)
<b>Subsidiary outcome measures</b>			
Symptom Check List (last week)			
SCL somatisation scale	0-48	21 (16-27)	21 (14-28)
<b>Other measurements</b>			
SCL depression scale	0-64	24 (16-36)	26 (17-37)
SCL anxiety + agoraphobia scale	0-68	19 (11-28)	17 (9-31)
Illness Attitude Scales (IAS)	0-96	41 (28-49)	37 (26-44)
Health anxiety scale in IAS	0-44	15 (8-23)	15 (7-21)
Symptom Attributions (% of patients) to			
purely somatic causes		39%	36%
psychosocial causes		12%	21%
both somatic and psychosocial causes		33%	31%
unknown causes		11%	8%
N of childhood problems	0-8	2 (1-3)	2 (1-3)
GP-judgement: Somatising patient		83%	82%
Difficult patient		64%	58%
Support from GP	0-100	50 (40-63)	48 (34-66)
<b>Social stresses</b>			
N of life events (preceding year)		2 (1-4)	3 (1-4)
Severity of chronic difficulties (preceding year)	0-60	6 (4-11)	8 (3-14)
Social support	0-100	68 (63-79)	69 (59-79)

a. N of missing values for each variable <5%, except for 'Sick leave': 71 (=35%) missing values

**Table 3** Changes in outcome variables: baseline versus 12 and 24 months follow-up. N=162

	Scale range	Reattribution N=75			Usual care N=87			Significance of differences between treatment groups <sup>a</sup>	
		Median	(inter-quartile range)		Median	(inter-quartile range)			
		t0	t12	t24	t0	t12	t24	t12 - t0	t24 - t0
<b>Main outcome measures</b>									
Medical consumption (preceding 6 months)									
N of health care visits		10 (4-23)	6 (3-14)	5 (2-13)	12 (7-24)	9 (5-20)	13 (5-25)	.628	.017*
N of different medicines		4 (3-5)	4 (3-5)	4 (4-5)	4 (3-5)	4 (3-5)	4 (3-5)	.673	.459
Subjective health (preceding month)	0-100	36 (26-50)	48 (35-66)	74 (34-87)	36 (19-54)	37 (29-57)	39 (22-54)	.016*	.000**
Sick leave in weeks (preceding 6 months)	0-26	5 (3-13)	0 (0-4)	0 (0-2)	4 (1-10)	3 (1-7)	4 (0-8)	.002**	.000**
<b>Subsidiary outcome measure</b>									
SCL somatisation scale	0-48	21 (16-27)	17 (12-24)	15 (11-23)	21 (16-27)	21 (15-28)	18 (14-26)	.004**	.002**

a. Mann-Whitney U test on differences between reattribution and usual care, in change of variables. \*: p< 0.05 \*\*: p< 0.01



patients visiting medical specialists and physiotherapists and a lower frequency of visits to the GP. The number of different medicines remained unchanged, although the percentage of patients using sedatives or painkillers decreased in the intervention group. An increase in the percentage of patients on antidepressants was observed in both treatment groups. Subjective health was improved: in the intervention group the influence of somatic symptoms on daily life decreased and patients felt healthier. From baseline to 12 months follow-up, changes were overall in the same direction as those between baseline and 24 months, but less marked.

Social stresses mostly remained stable in both treatment groups, during two-year follow-up: social support and number of life events remained unchanged, severity of longstanding difficulties decreased only in the reattribution group, from median 6 to 5 ( $p = .002$ ), but the difference between the treatment groups was not significant ( $p = .062$ ). Ranking of intervention versus control practices according to descending effect size (subjective health) yielded the following sequence: C-I-I-I-I-I-I-I-C-I-C-C-C-C-C-C-C. Within the reattribution group the variable 'practice' did not influence the outcome measures significantly ( $p$ -value .920 for subjective health, .745 for medical consumption and .427 for sick leave).

Subgroups with high versus low baseline levels of IAS-health anxiety, SCL-anxiety, DSM-somatisation, frequency of visits to the GP, showed no differences in response to treatment. High SCL-depression scores were associated with a decrease in subjective health in the usual care group. 'True somatisers', who at baseline attributed all symptoms to somatic or unknown causes, responded equally to treatment as 'part somatisers', who mentioned psychological attributions as well.

Extra analyses were performed on patients in intervention practices, who had given informed consent, but were not selected for the reattribution group, and who were followed outside the trial ( $n=42$ , data not presented in the Tables). Their subjective health increased during two-year follow-up from (median) 36 to 49, while the number of health care visits increased from (median) 7 to 11, and sick leave remained stable (median 4, respectively 3 weeks). On all outcome measures, differences with the reattribution group were significant and comparable to those of the usual care group.

## DISCUSSION

Our trial shows that reattribution, applied by the patients' own GPs, is effective in lowering medical consumption, especially visits to medical specialists, physiotherapists and GPs. The effect size is comparable to that of a study in which GPs received a consultation letter on the management of somatisation, a far more simple intervention<sup>30</sup>. The consultation letter, however, has no effect on subjective health. In our study, subjective health improves markedly. The effects of our intervention can be compared with earlier studies on cognitive behavioural interventions for somatisation. Speckens<sup>12</sup> found a reduction in intensity of physical symptoms and an improvement of sleep and social activities, but no effect on work or household and no change in health anxiety (IAS), 6 and 12 months after CBT (6-16 sessions), applied to somatising medical outpatients. Lidbeck<sup>31</sup> reported a moderate improvement of physical illness, somatic preoccupation, hypochondria and medication usage, and no effect on sleep, depression and anxiety, six months after group CBT (8 sessions) for somatisation in general practice. The only before-after study on reattribution<sup>32</sup> reported a decrease of visits to health care from 2.9 to 1.9 over three months and a 23% fall in health care costs outside primary care. Altogether, reattribution appears at least as effective with respect to medical consumption and subjective health as the above, more comprehensive cognitive-behavioural interventions. An explanation might be, that reattribution is applied by the patient's own GP, who can give a 'reattribution booster', whenever a somatising patient presents illness worries or unexplained physical symptoms. Our third main outcome measure, sick leave, decreases relevantly and significantly. This variable, however, had 35% missing values: many full-time housewives skipped the question, although household was explicitly defined as work. Although effects of reattribution are impressive, medical consumption and health anxiety remain considerably higher than in non-somatising patients in general practice. In summary, reattribution improves illness behaviours and health, but nevertheless patients remain somatisers. This finding supports the concept of somatisation as a chronic tendency towards abnormal illness behavior. This implies that even after successful reattribution, doctors should remain alert on new episodes of somatisation, and be willing to go through the stages of reattribution repeatedly.

The original reattribution model has appeared to be effective for 'part somatisers', who are at least partly able to consider emotional causes for their symptoms, whereas the more severe 'true somatisers', do not react. With our modifications, reattribution has shown to be as effective in true, as in part somatisers.

## METHODOLOGICAL CONSIDERATIONS

Patient selection and enrolment were performed by the research team, in order to guarantee the required number of patients and to prevent selection bias, major problems in studies in which GPs perform both selection and intervention<sup>33</sup>. As a consequence, among the participating patients 20% did not somatise according to their GPs, and in six patients of the intervention group, ‘no somatisation’ was the reason why GPs did not start reattribution.

A methodological infirmity of this study is the “fallacy of the wrong level”: randomisation was necessarily performed on practice level to avoid contamination, whereas analysis was performed on patient level. Statistically, a larger number of practices with a smaller number of participating patients per practice is to be preferred. However, it is not efficient to train 25 GPs to treat 75 intervention patients.

The study population represents the broad spectrum of severity of somatisation seen in general practice. Although the trial population had been somatising for at least three years, there is no reason to assume that the results will be less favourable in short-standing somatisation. Results can not be generalised, however, to patients aged over 45, in whom somatic attributions may be more fixed, and increased prevalence of somatic disease may make it more difficult to differentiate between symptoms of disease and symptoms of somatisation. Immigrants were underrepresented in our study, due to language and cultural factors. Both factors probably will interfere with application of reattribution too, so results can not be generalised to immigrant patients.

## IMPLICATIONS FOR GENERAL PRACTICE

This trial has enhanced the already growing evidence for the effectiveness of reattribution as therapeutic approach to the both frequent and difficult problem of somatisation in general practice. Although these results are encouraging, it is questionable, whether GPs will welcome reattribution as a new therapeutic tool. Firstly, the training package is time-expensive (20 hours). Secondly, applying reattribution requires that an extra effort be put into heart-sink patients, while it is reported that GPs are not willing to perform psychological interventions on somatising patients<sup>34</sup>. On the other hand, once GPs are trained to perform reattribution, application in practice is time-neutral: longer duration of consultations is out-waged by a lower frequency of visits (frequency decreases in the intervention group from median 7 to 5.5). Moreover, GPs report a need for effective management strategies: on priority lists for postgraduate courses treatment for somatisation

gets high scores<sup>8</sup>. GPs in our study evaluated reattribution as a useful additional consultation skill, feasible to be applied to a maximum of five to 10 patients a year. We conclude, that implementation of reattribution as a standard consultation skill for all GPs will probably not be feasible, but for GPs who are willing to improve their approach to somatising patients, the modified reattribution model is the best available option.

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## Chapter 5

### **Predictors of prognosis in long-term somatisation in primary care, the role of stress**

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*To be submitted*



## ABSTRACT

**Background** The natural course of somatisation and predictors of prognosis are important in the allocation of time-intensive management strategies for somatisation in general practice. We studied whether subjective health, sick leave, health care visits, and use of medicines were predicted by frequency of GP attendance in previous years and by stress factors, in somatising patients.

**Methods** 376 frequently attending somatisers, between 20 and 45 years of age, in 27 general practices, filled in questionnaires at baseline, and at one- and two-year follow-up. Data were collected on the outcome measures (subjective health, sick leave and medical consumption) and on GP attendance in the previous three years, problems in childhood, life events, chronic difficulties, and social support.

**Results** Overall, outcome measures were stable in the total group of somatising patients. Chronic difficulties and life events were strong cross-sectional indicators of outcome. Only social support had an independent long-term protective effect on outcome, increasing over time.

**Conclusion** We are far from being able to predict which patients, among those with a chronic tendency to somatisation, will become increasingly disabled or dependent on health care. When selecting somatising patients who need treatment most, GPs should focus on patients with impaired subjective health and high medical consumption, especially those who lack social support.

## INTRODUCTION

Somatisation is a highly prevalent problem in general practice with major consequences for patients' subjective health, disability and medical consumption.<sup>1,2</sup> Most general practitioners (GPs) consider somatising patients to be difficult<sup>3</sup> or even frustrating<sup>4</sup>, and a resulting rejecting attitude of GPs may give patients the feeling that the reality of their symptoms is denied.<sup>5</sup> Effective 'retribution' treatment of somatisation in primary care has been described lately, with improvement of health and a considerable decrease in medical consumption.<sup>6</sup> However, these treatments require thorough training of GPs and an extra initial time investment per somatising patient. Therefore, limitation of the number of somatising patients to be treated per practice seems realistic.<sup>7</sup> In order to provide treatment for the group of highest need, the natural course of somatisation and predictors of prognosis have to be known. Obviously, somatisers who are not doing well at present (low subjective health, high frequency of sick leave, frequent attendance, and high medical consumption) should receive priority of treatment.<sup>8,9</sup> The question arises, which additional factors can help the GP to predict which patients will deteriorate, and who will recover spontaneously. The level of stresses in the patient's life may influence which patients increasingly become disabled and dependent on health care.<sup>1,10,11</sup> Life events, chronic difficulties, a problematic childhood and poor social support have been identified as stress factors.<sup>12-15</sup>

The aims of this study are (a) to describe the clinical course of general practice patients who have been somatising in previous years, in terms of subjective health, sick leave, visits to health care, and use of medicines, and (b) to identify stress factors that predict the prognosis over a two-year period.

## METHODS

For this study, data from two studies with identical design and inclusion criteria, testing two interventions (retribution and disclosure) for somatisation, were pooled.<sup>7,16</sup>

## RECRUITMENT OF PATIENTS

Frequently attending patients, between 20 and 45 years of age, received a postal questionnaire inquiring into any somatisation symptoms they had experienced during their life. Frequent attendance was defined as 15 contacts or more (on the patient's initiative) with

their GP, in the previous three years. We estimated this would select the 10% most frequently attending patients for this age group in the Netherlands.<sup>17,18</sup> The somatisation questionnaire, which was developed by the authors and appeared to be feasible in a pilot study, contained the 37 somatisation symptoms listed in DSM-III-R, with the pertinent follow-up questions, listed in DSM-III-R (Diagnostic Statistical Manual of Psychiatric Disorders, 3<sup>rd</sup> revised edition<sup>19</sup>). Symptoms counted when not explained by use of medicines, alcohol, or drugs, and when not explained by organic disease (based on the examination of the GP or specialist, as reported by the patient in the questionnaire). Frequently attending patients reporting five or more somatisation symptoms in their lifetime (Somatic Symptom Index, SSI 5/5) were eligible for the study.<sup>2,20,21</sup> Patients with the following serious somatic or mental diseases were excluded: cancer, AIDS, rheumatoid arthritis, multiple sclerosis, dementia, schizophrenia, mental retardation, and psychosis. Patients with other chronic diseases, such as asthma, osteoarthritis, or cardiovascular diseases, were not excluded to maintain a high generalisability for patients in primary care.

## OUTCOME MEASURES AND OTHER VARIABLES

At baseline, at one and at two years after entry in the study, patients completed questionnaires on outcome measures. Subjective health last month (0 is very bad health, 100 is excellent health) was operationalised as the average of (a) a direct question on health (visual analogue scale), and (b) a combined score of six questions on the influence of symptoms on work, sleep, sport activities, social life, mood, and ruminating about being ill. Sick leave was expressed in weeks absent from work (or household activities) because of illness, over the previous six months. Medical consumption over the previous six months was calculated as (a) the total number of visits to all health care workers, and (b) the number of different medicines used daily for at least a week.

Possible predictors of somatisation were measured at baseline. Social support (1) was the average support of the five most important persons in the patient's life (0 is no support, 100 is very much support). Chronic difficulties (2) consisted of a list of 20 long-term problems, scored on four-point scales (0 is no problem, 3 is severe problem) in relations with relatives and friends, or situations such as work, housing, and financial affairs.<sup>22</sup> On a checklist of 29 events, patients reported the number of life events in the previous year. Childhood problems (until the age of 18) comprised a checklist of questions on lack of parental care (death, divorce, nervous breakdown of parent(s), living in an institution, foster home, or boarding school), too much responsibility as a child, and an open question on abuse

or other severe events or circumstances in childhood.<sup>15,23</sup> Abuse was defined as any serious, threatening, and unwanted sexual experience or beating. An occasional non-threatening sexual experience with playmates, or non-threatening physical reprimand was not counted as abuse.<sup>24</sup> Each childhood event could only count in one category, adding up to a total score between zero and eight.

## STATISTICAL ANALYSIS

Since the measures of outcome had skewed distributions, non-parametric tests were used throughout. To analyse the influence in time of possible predictors on outcome, bivariate analyses were performed with the four measures of outcome at the baseline, one-year and two-year follow-ups. As a next step, the four measures of outcome were dichotomised at their median scores to allow logistic regression. Separate logistic regression models (LR-backward elimination) were used to analyse the influence of predictive factors at the two-year follow-up, after the baseline outcome and patient's trial-intervention status were forced into the models. Odds ratios were calculated (a) per point of scale of predictors and (b) from the 10th to the 90th percentile of predictors, to allow direct comparison between predictors. In extra sets of analyses, patients receiving reattribution and disclosure interventions were removed from the analyses to assess whether this influenced the results.

## RESULTS

A total of 376 somatising patients from twenty-seven practices (12 in Amsterdam, 15 in Maastricht) participated in the study. After one reminder, 336 questionnaires were returned at one year and 339 at two years. The 14 patients not responding to both follow-up questionnaires were very similar to the respondents, except for a higher frequency of immigrants (36% versus 11%).

Patients from both locations were very similar in baseline characteristics (Table 1). More Amsterdam than Maastricht patients were living alone, patients in Amsterdam had, on average, a slightly higher level of education and work, and more often had an immigrant background. Patients in Amsterdam reported slightly lower subjective health, had made more

**Table 1** Baseline characteristics

	Scale	Amsterdam N = 171 median <sup>a</sup>	Maastricht N = 205 median <sup>a</sup>	All patients N = 376 median <sup>a</sup>
<b>Sociodemographic characteristics</b>				
Age in years	20-45	36	37	37
Female sex <sup>a</sup>		85.0%	82.0%	83.5%
Married or cohabiting <sup>a</sup>		82.7%	96.1%	89.9%
Educational status: low		39.0%	50.5%	45.1%
middle		44.2%	45.5%	44.9%
high		16.9%	4.0%	10.0%
Professional status: low		66.1%	62.4%	64.1%
middle		23.2%	34.0%	29.0%
high		10.7%	3.6%	6.8%
Immigrant status <sup>a</sup>		17.9%	5.4%	11.2%
Paying job <sup>a</sup>		56.1%	53.7%	54.8%
<b>Outcome measures</b>				
Medical consumption				
N of visits to all health care <sup>b</sup>		10	7	8
N of different medicines <sup>b</sup>		2	2	2
Subjective health previous month	0-100	39	45	42
Sick leave in weeks <sup>b</sup>	0-26	4	2	3
<b>Other measurements</b>				
GP consultations previous 3 years	15-	19	21	20
DSM somatisation	5-37	7	8	7
Social support	0-100	43	40	42
Life events		2	2	2
Chronic difficulties		6	7	7
N of childhood problems	0-8	2	2	2

a. Median for continuous variables, percentage for nominal variables

b. Preceding six months

**Table 2** Main outcome measures at baseline, at one- and at two-years follow-up. N = 376

	range	t0 median (iqr <sup>a</sup> )	t12 median (iqr <sup>a</sup> )	t24 median (iqr <sup>a</sup> )	t24-t0 median (iqr <sup>a</sup> )
Subjective health	0-100	42 (27 ; 60)	45 (31 ; 64)	50 (30 ; 71)	+5 (-11 ; +20)
Sick leave	0- 26	3 (0 ; 7)	1 (0 ; 4)	2 (0 ; 6)	0 (-3 ; +3)
N of visits all health care	0- 83	8 (3 ; 20)	8 (3 ; 15)	8 (3 ; 18)	-1 (-9 ; +8)
N of different medicines	0- 9	2 (1 ; 3)	2 (1 ; 3)	2 (1 ; 3)	0 (-1 ; +1)

a. Inter-quartile range

**Table 3** Bivariate analyses (Spearman's rank correlation) between predictors of outcome and baseline, one- and two-year follow-up data. N = 376

	GP cons. 3 years	Social support	Life events	Chronic difficulties	Childhood problems
<b>Baseline</b>					
Subjective health	-0.17**	0.13*	-0.17**	-0.42***	-0.10
Sick leave	0.12*	0.03	0.19**	0.13*	0.10
N of health care visits	0.18***	0.04	0.12*	0.24***	0.11*
N of medicines	0.09	0.01	0.08	0.23***	0.15**
<b>One-year follow-up</b>					
Subjective health	-0.09	0.18**	-0.08	-0.18**	0.02
Sick leave	0.06	-0.06	0.16**	0.15*	0.11*
N of health care visits	0.18**	-0.12*	0.04	0.12*	0.11*
N of medicines	0.11*	-0.08	0.07	0.19**	0.08
<b>Two-year follow-up</b>					
Subjective health	-0.07	0.16**	-0.02	-0.12	0.01
Sick leave	0.12*	0.04	0.10	0.01	0.04
N of health care visits	0.10	-0.20***	0.01	0.14*	0.11*
N of medicines	0.14*	0.00	0.05	0.06	0.08

\*,p<0.05; \*\*,p<0.01; \*\*\*,p<0.0

visits to health care professionals, and reported more weeks of sick leave over the previous six months.

Patients reported, on average, a rather low subjective health of 42, were absent from their work for 3 weeks, had visited a health care professional eight times and had taken two different medicines, in the previous six months. The outcome variables remained stable over the follow-up period of two years (Table 2). Individual patients, however, varied considerably in subjective health, sick leave, health care visits and use of medication over the two years.

Chronic difficulties and, to a lesser extent, GP consultations in the previous three years correlated strongly with the different measures of outcome at baseline, but gradually lost predictive power during the two follow-up years (Table 3). Life events in the previous year correlated with baseline outcome data, but rapidly lost predictive power at one and two years. Social support hardly correlated with baseline outcome, but gained predictive power for subjective health and number of health care visits during the follow-up period. A problematic childhood was a weak predictor at baseline and at follow-ups.

In the regression analyses, the best independent predictors of outcome at the two-year follow-up were the baseline subjective health and medical consumption (Table 4).

**Table 4** Logistic regression model between predictors at baseline and two-year outcome measures. N=376

Two-year follow-up													
	Scale	Subjective health model 1 <sup>a</sup>			Sick leave model 2 <sup>a</sup>			Health care visits model 3 <sup>a</sup>			Medicines model 4 <sup>a</sup>		
		OR <sup>b</sup>	OR <sup>c</sup>	sign.	OR <sup>b</sup>	OR <sup>c</sup>	sign.	OR <sup>b</sup>	OR <sup>c</sup>	sign.	OR <sup>b</sup>	OR <sup>c</sup>	sign.
<b>Block 1</b>													
Subjective health at baseline	0-100	1.031	6.64	0.000	-	-	-	-	-	-	-	-	-
Sick leave at baseline	0-26	-	-	-	1.020	1.64	0.309	-	-	-	-	-	-
N of health care visits at baseline	0-83	-	-	-	-	-	-	1.019	1.79	0.041	-	-	-
N of medicines at baseline	0-9	-	-	-	-	-	-	-	-	-	1.575	6.15	0.000
<b>Block 2</b>													
Disclosure intervention (N=80)		0.548	0.036		1.756		0.113	0.635		0.179	0.004		0.987
Reattribution intervention (N=75)		1.622	0.152		0.662		0.328	0.569		0.096	0.284		0.000
<b>Block 3</b>													
GP consultations previous 3 years	15-												
Social support	0-100	1.031	2.15	0.050	1.034	2.31	0.047	0.954	0.31	0.002			
Life events	0-							0.898	0.52	0.089			
Chronic difficulties	0-												
Problems in childhood	0-8												
<b>Total variance of model<sup>d</sup></b>		18.1%			5.5%			8.8%			18.0%		

- Logistic regression models (reduced model, backward elimination, P-in: 0.05, P-out: 0.10) after the baseline data and the intervention status (blocks 1 and 2) were forced into the models
- Odds Ratio per point of change on the scale of predictors
- To allow comparison between different predictors, Odds Ratios were calculated from 10th to 90th percentiles of responses of predictors.
- Nagelkerke's  $r^2$

Additionally, higher social support was associated with better subjective health and low numbers of health care visits. Strong social support seemed to be associated with more sick leave (in women); this finding, however, was not consistent with the bivariate analysis. Life events showed a trend towards predicting health care visits at two years follow-up. The total explained variance of the different predictive models remained very modest. At one year (data not presented) social support predicted subjective health and health care visits, problems in childhood predicted sick leave, and GP consultations in the previous three years predicted health care visits, with a total explained variance in the same range as the two-year data. Removal of the reattribution intervention group did not change the results. After removal of the disclosure group, social support no longer predicted sick leave.

## DISCUSSION

Somatising patients in this study are best described as patients with relative poor sense of well-being, high medical consumption, and frequent sick leave, especially during stressful periods. Although individual patients varied considerably over time, a finding which is in line with earlier studies on somatisation in general practice<sup>25</sup>, overall outcome measures were stable in the total group of patients over two years. This finding is not surprising, since we did not specifically select patients with somatisation complaints at the start of the study. Our focus was on patients with a prior tendency to develop somatisation symptoms.

The stressors chronic difficulties and life events showed strong cross-sectional correlations with clinical condition in our group, but lost most of their predictive power at the one- and two-year follow-ups. Our interpretation was that patients recovered from (or adjusted to) the stressful situation and their somatisation symptoms subsided. Childhood problems did not predict unfavourable outcome. A number of studies have shown a greater influence of childhood experiences on somatisation; however, these were all studies comparing somatisers with non-somatisers,<sup>13,15,26,27</sup> whereas we studied clinical course within a group of somatising patients. Only social support had an independent long-term effect on outcome, increasing over time, which strongly suggested low social support to be a risk factor for deterioration in somatisers. Other authors have found similar results, both in the general population and, more specifically, in somatising patients.<sup>28,29</sup> Nevertheless, we are far from being able to predict which somatising patients will become progressively disabled or dependent on health care.



Subjective health and use of medicines at baseline were the best predictors of outcome in our study. For daily practice this implies that patients with poor subjective health and high use of medication are the ones at risk of later deterioration, especially when they have weak social support. In these patients active intervention may be indicated. Patients known as somatisers, who are doing relatively well at the moment, are preferably not selected for interventions.

## METHODOLOGICAL CONSIDERATIONS

A limitation of this study was that we used data sets of two intervention studies, one of which proved to be effective.<sup>7</sup> We made the choice to include intervention patients as well, and entered the intervention status as a modifier early in the regression analysis. The power of this study was too small to enter the interaction variables of intervention status and other predictors. Either of the two interventions may have influenced our results slightly.

## CONCLUSIONS AND RECOMMENDATIONS

We could not confirm that stresses makes long-term somatising patients more prone to deterioration of their clinical condition over time, except for low social support. GPs who want to select long-term somatisers needing active intervention should focus on patients with a poor sense of well-being and high medical consumption, especially those who lack social support.

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## Chapter 6

### **Clinical judgement on somatisation in general practice, diagnostic and predictive validity**

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*To be submitted*

## ABSTRACT

**Objective** Aim of this study was to evaluate the diagnostic and predictive value of general practitioners' (GP-) judgement on somatisation in frequent attenders.

**Methods** Data from two twin studies were pooled. In 713 frequent attenders aged 20-45, DSM somatisation symptoms were measured by postal questionnaire. For each patient, GP-judgement was asked on somatisation, on perception of the patient as difficult, and on specified aspects of communication. Overlaps of GP-judgements with DSM somatisation were calculated. In a subgroup with DSM somatisation the SCL somatisation scale was applied (N=311), and clinical course was measured (over two years) by patient questionnaires on subjective health, sick leave, total number of health care visits and number of medicines.

**Results** Those frequent attenders who ask superfluous examinations or treatments and who behave helpless according to their GP, are more likely to be labelled as somatising patient; 73% of the somatising frequent attenders were judged as 'difficult', especially those whom the GP likes less. Neither the GP-judgement on somatisation, nor standardised somatisation measures (DSM score, SCL somatisation scale) contributed substantially to a prediction of clinical course over two years, in frequent attenders with DSM somatisation.

**Conclusions** Since the majority of somatising patients is judged as difficult, interventions on somatisation in general practice should address problems in doctor-patient communication. In frequent attenders with medically unexplained symptoms, GPs cannot rely on their judgement on somatisation to predict which patients will deteriorate. Multidimensional diagnostic criteria for somatisation are recommended, to enhance predictive power.

## INTRODUCTION

Somatising patients, as defined by Lipowski<sup>1</sup>, frequently experience and present physical symptoms, which they attribute to physical illness, whereas their doctors do not find physical pathology which accounts for the symptoms. Somatising patients are mainly cared for in general practice. General practitioners (GPs) often describe somatising patients as 'misusers'<sup>2</sup>, and as difficult or even heart-sink patients<sup>3</sup>. Little is known about criteria, used by GPs in labelling frequent attenders as 'somatising' or as 'difficult' patients. While research on somatisation uses standardised symptom counts to determine whether patients are somatising, GPs in daily practice rely on their clinical judgement. Schilte<sup>4</sup> reported that GPs' clinical judgement on somatisation, within a group of frequently attending patients, was strongly influenced by attendance rate and by GPs' impression of communication with the patient, whereas standardised measurements incorporated more psychiatric problems, especially depression and anxiety disorders. Apparently, if symptoms of depression or anxiety are present, GPs prefer to label patients as depressive or anxious rather than somatising. These differences in patient profiles are relevant, since conclusions from research on patients who somatise according to standardised measures, are being applied to patients who somatise according to GP clinical judgement. If these populations differ in clinical course, indications for interventions and effectiveness of interventions will differ too.

In the present study, GP-judgements on somatisation and on difficulty of the patient are compared to two frequently used standardised somatisation measures: DSM somatisation, for which five medically unexplained physical symptoms lifetime are required<sup>5, 6</sup>, and the somatisation scale of the Symptom Check List (SCL)<sup>7</sup>. Research questions are: (1) which aspects of communication, as perceived by the GP, contribute to GP-judgement of frequent attenders as 'somatising' or as 'difficult' patient, and (2) what is the predictive value of GP-judgement on somatisation (in comparison to standardised somatisation measures) for clinical course over two years?

## METHODS

For this study data from two studies with identical design and selection criteria, which tested two interventions (reattribution and disclosure) for somatisation, were pooled.<sup>8, 9</sup>

## RECRUITMENT OF PRACTICES

In the region of Amsterdam, 15 GPs from 12 practices were recruited, who had not attended courses on somatisation or on cognitive behavioural therapy, and had been working in their present practice for at least five years. In the region of Maastricht 15 practices were recruited from the Registration Network of General Practices.

## RECRUITMENT OF PATIENTS

Frequently attending patients, between 20 and 45 years of age, were selected. Frequent attendance was defined as 15 contacts or more with the GP (on the patient's initiative) in the previous three years, representing the 10% most frequently attending patients for this age group in the Netherlands<sup>10</sup>. Frequencies of GP attendance during the previous three years and during a two-year follow-up, were extracted from practice records. Somatisation was assessed by a postal questionnaire, which was developed by the authors and had appeared to be feasible in a pilot study. The questionnaire contained the 37 somatisation symptoms listed in DSM-III-R, with the pertaining follow-up questions listed in DSM-III-R (Diagnostic Statistical Manual of psychiatric disorders, edition III revised). Symptoms counted when not explained by use of medicines, alcohol or drugs, and when not explained by organic disease (based on the examination of the GP or specialist, as reported by the patient in the questionnaire).<sup>5, 6</sup>

Patients with the following serious somatic or mental diseases were excluded: cancer, AIDS, rheumatoid arthritis, multiple sclerosis, dementia, schizophrenia, mental retardation and psychosis. Patients with other chronic diseases, e.g. asthma, osteoarthritis, or cardiovascular diseases, were not excluded to maintain a high generalisability for patients in primary care.

## MEASUREMENT INSTRUMENTS

For all patients with a DSM score  $\geq 5$  (N=463) and for a random sample (N=250) out of about 600 patients scoring  $\leq 4$ , GP-judgement was asked on somatisation and on aspects of doctor-patient communication. By that time, GPs had not received any specific information or training on somatisation. GP-judgement was measured by a short questionnaire consisting of nine five-point Likert scales (ranging from 1 = not at all to 5 = very much), on somatisation, on perceived difficulty of the patient, and on seven specified aspects of communication: inadequate help-seeking behaviour, patient's willingness to discuss psychosocial aspects,

patient asks for superfluous examinations or treatments, helpless behaviour of patient, GP experiences patient as tiresome, GP likes patient, and patient makes GP feel powerless.

Clinical course was measured only in trial participants, at baseline and after 12 and 24 months, by postal questionnaires on four aspects. Subjective health (I) was calculated over the preceding month, as the combined score on visual analogue scales on (a) the influence of actual symptoms on work, sleep, sport/exercise, social life, mood and ruminating about symptoms, and (b) a direct question on health. Sick leave (II) was measured as absence from work or household through illness, in weeks during the previous six months. Medical consumption over the preceding six months was measured as (III) the number of visits to all health care workers including GPs, and (IV) the number of different medicines used for more than one week. Additionally, symptoms of somatisation, depression and anxiety/agoraphobia were measured with the corresponding SCL scales <sup>7</sup>.

## STATISTICAL ANALYSIS

The first research question was studied in the group of frequent attenders from whom the GP-judgement was measured (N=713). For the second research question data were used from patients participating in the trial, with exception of patients randomised to the Amsterdam reattribution intervention because this intervention had appeared to be effective (N=311).

To answer the first study question, possible determinants of the GP-judgement on somatisation were entered into a backward step-wise linear regression model: practice (transformed into dummy variables), number of visits to the GP during the previous three years, number of DSM somatisation symptoms, GP-judgement on difficulty of the patient and on seven aspects of communication. An analogue regression model was applied to the GP-judgement on difficulty of the patient. In a circle diagram the overlap was displayed between the patient groups group with DSM somatisation and the groups labelled by their GPs as 'somatising' and as 'difficult' (score  $\geq 3$  on the corresponding 5-point Likert scales).

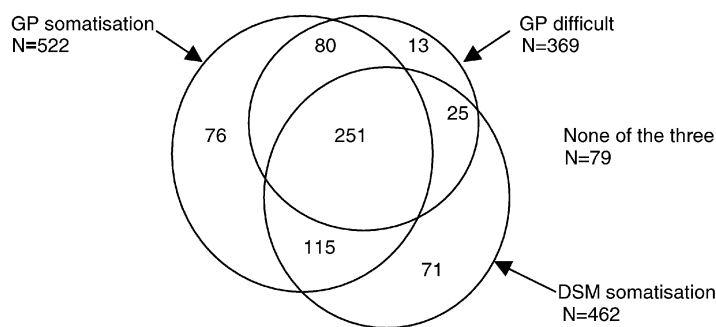
The second research question required a more complex analysis: for all three somatisation measures separately, predictive values for the four measures of clinical course were investigated. Firstly, bivariate Spearman rank correlations between somatisation measures and clinical course data were calculated. Subsequently, separate linear regressions were performed for each measure of clinical course (I, II, III and IV) on each of the somatisation measures (A, B, and C) and on the perceived difficulty of the patient. In each regression analysis the baseline score of the respective clinical course measure was forced



into the model first. For instance, regression model IA tests whether subjective health at two year follow-up was predicted by subjected health at baseline, and if the GP-judgement on somatisation added to this prediction.

## RESULTS

Concerning the first research question, it can be seen from Figure 1 that the majority of frequent attenders who somatised according to their GP, were judged as difficult patients (331 out of 522 patients = 63%), while GPs judged only a small proportion of the non-somatising frequent attenders as difficult (38 out of 188 patients = 20%). GP somatisation correlated stronger than DSM somatisation with GP-judgement on difficulty of the patient. A specification of those aspects of doctor-patient communication which make frequent attenders difficult, is shown in Table 1. The variable 'patient asks superfluous examinations or treatments' explained 38% of the variance in the GP-judgement on somatisation, and together with 'helpless behaviour of the patient' 45% was explained. The variable 'practice' explained 5% of the variance. In Table 2 factors are presented that contributed significantly to the GP-judgement on difficulty of the patient. The variable 'GP likes patient' (negative correlation) explained 27%, and together with 'patient asks superfluous examinations' and 'GP-judgement on somatisation' 44% of the variance was explained. 'Practice' explained 9%.



**Figure 1** Overlap between DSM somatisation, GP-judgement on somatisation, and GP-judgement on difficulty in 710 frequent attenders (462 with, and 248 without DSM somatisation)

**Table 1** Determinants of GP-judgement on somatisation in frequent attenders: multiple linear regression. N=713

	Model 1A <sup>a</sup> Adj. R <sup>2</sup> .503 beta <sup>b</sup> (sign)	Model 1B Adj. R <sup>2</sup> .478 beta <sup>b</sup> (sign)	Model 2A <sup>a</sup> Adj. R <sup>2</sup> .481 beta <sup>b</sup> (sign)	Model 2B Adj. R <sup>2</sup> .461 beta <sup>b</sup> (sign)	Model 3A <sup>a</sup> Adj. R <sup>2</sup> .464 beta <sup>b</sup> (sign)	Model 3B Adj. R <sup>2</sup> .449 beta <sup>b</sup> (sign)	Model 4A <sup>a</sup> Adj. R <sup>2</sup> .402 beta <sup>b</sup> (sign)	Model 4B Adj. R <sup>2</sup> .383 beta <sup>b</sup> (sign)
N of visits to GP (3 years)	.079 (.007)	.075 (.007)						
Patient asks for superfluous examinations/treatments	.349 (.000)	.351 (.000)	.416 (.000)	.418 (.000)	.489 (.000)	.488 (.000)	.617 (.000)	.619 (.000)
Helpless behaviour of patient	.202 (.000)	.202 (.000)	.238 (.000)	.238 (.000)	.293 (.000)	.288 (.000)		
Difficult patient	.110 (.187)	.095 (.251)						
Tiresome patient	.156 (.000)	.131 (.000)	.184 (.000)	.159 (.000)				
Difficult * superfluous ex/tr	.010 (.930)	.020 (.853)						
Difficult * GP likes patient	.080 (.035)	.060 (.102)						

a. Variable 'practice' (expressed in dummy-variables) is forced into the model first

b. Standardised regression coefficient

**Table 2** Determinants of GP-judgement on difficulty of frequent attenders: multiple linear regression. N=713

	Model 1A <sup>a</sup>	Model 1B	Model 2A <sup>a</sup>	Model 2B	Model 3A <sup>a</sup>	Model 3B
	Adj. R <sup>2</sup> .503	Adj. R <sup>2</sup> .478	Adj. R <sup>2</sup> .481	Adj. R <sup>2</sup> .461	Adj. R <sup>2</sup> .464	Adj. R <sup>2</sup> .449
	beta <sup>b</sup> (sign)	beta <sup>b</sup> (sign)	beta <sup>b</sup> (sign)	beta <sup>b</sup> (sign)	beta <sup>b</sup> (sign)	beta <sup>b</sup> (sign)
N of visits to GP (3 years)	.025 (.380)	.005 (.853)				
GP likes patient	-.283 (.000)	-.267 (.000)	-.282 (.000)	-.265 (.000)	-.391 (.000)	-.351 (.000)
Patient makes GP powerless	.172 (.000)	.120 (.000)	.179 (.000)	.121 (.000)		
Patient asks for superfluous examinations/treatments	-.118 (.320)	-.249 (.038)				
GP-judgement on somatisation	.087 (.243)	-.069 (.347)				
Tiresome patient	.343 (.004)	.351 (.005)	.137 (.000)	.118 (.001)	.413 (.000)	.456 (.000)
Somatisation * Superfluous ex/tr	.395 (.018)	.643 (.000)	.247 (.000)	.270 (.000)		
Somatisation * Helpless	.085 (.089)	.169 (.001)	.099 (.019)	.144 (.001)		
Somatisation * Tiresome	-.290 (.069)	-.316 (.057)				

a. Variable 'practice', expressed in dummy-variables, is forced into the model first

b. Standardised regression coefficient

**Table 3** Bivariate correlations<sup>a</sup> between somatisation measures and clinical data at baseline (t0) and at two year follow-up (t24)

	Subjective health		Sick leave		N of health care visits		N of different medicines	
	t0	t24	t0	t24	t0	t24	t0	t24
Somatisation measures:								
GP-judgement on somatisation	-.033	-.151*	.161*	.066	.122	.052	.013	.005
DSM-III-R somatisation symptoms	-.171**	-.181**	.002	.023	.015	.075	-.034	.049
SCL somatisation scale (last week)	-.526***	-.249***	.213**	.130*	.165**	.201**	.090	.109
GP-judgement on difficulty	.075	-.170**	-.011	.022	.048	.109	.049	.031

a. Spearman rank correlation coefficient

\*; p< 0.05 \*\*; p< 0.01 \*\*\*; p< 0.001

**Table 4** Predictive value of somatisation measures for clinical course over two years<sup>a</sup>

Baseline data	Clinical course at two-year follow-up				
	Scale range	I. Subjective health	II. Sick leave	III. N of health care visits	IV. N of different medicines
		$r^2$ <sup>b</sup>	$r^2$ <sup>b</sup>	$r^2$ <sup>b</sup>	$r^2$ <sup>b</sup>
Subjective health (preceding month)	0-100	.13***			
Sick leave in weeks (preceding 6 months)	0-26		.03**		
N of health care visits (preceding 6 months)				.00	
N of different medicines (preceding 6 months)					.41***
Somatisation measures:					
A. GP-judgement on somatisation	1-5	.14**	.03	.00	.41
B. DSM-III-R somatisation symptoms	0-37	.15	.03	.03	.43 **
C. SCL somatisation scale (last week)	0-48	.14	.06*	.05**	.42
GP-judgement on difficulty	1-5	.15**	.03	.01	.41

- a. Separate linear regressions for each somatisation measure (A, B, C) and for GP-judgement on difficulty.
- b. For each outcome (I, II, III, IV), baseline value of the outcome measure is forced into the model first.
- c. Adjusted variance: percentage of variance in outcome which is explained by baseline value of the outcome measure plus this predictor, with significance of the contribution of this factor to the explained variance in outcome. \*:  $p < .05$  \*\*:  $p < .01$  \*\*\*:  $P < .001$

With regard to the second study question, Table 3 indicates significant, moderate, negative correlations for all somatisation measures with subjective health two years later. Only the SCL somatisation score was moderately correlated to sick leave and health care visits. However, as is shown in Table 4, none of the somatisation measures added substantially to the prediction of clinical course over two years: 41% of the variance in use of medicines, 13% of the variance in subjective health, and hardly any variance in sick leave or health care visits at two years were explained by their baseline values, and none of the somatisation measures added more than a few percents to the explained variances. Stability in time of GP-judgement on somatisation, expressed in partial correlation coefficient between baseline and two years later, controlling for changes in clinical course, was .4978 ( $p < .001$ ). SCL somatisation was more stable (.7578 ( $p < .000$ )).

## DISCUSSION

In answer on our first research question we have found that, in frequent attenders, GP's clinical judgement on somatisation is largely determined by two aspects of doctor-patient communication (as perceived by the GP), namely 'patient asks for superfluous examinations and treatments' and 'helpless behaviour of the patient'. It strikes that factors which reflect emotions of the doctor, like 'GP likes patient' (negative correlation) and 'patient makes me feel powerless', which do make a frequent attender difficult, do not contribute to the GPs' conclusion that the patient is somatising. Apparently GPs are able to 'turn the microscope to themselves', as is advised by Neal<sup>11</sup> in order to recognise the role which their own feelings play in the communication with somatising patients, while at the same time they turn the microscope to the patient in order to assess somatisation. The finding that GPs label three quarters of their somatising patients as 'difficult', has implications for interventions on somatisation in general practice. On the one hand, GPs might be motivated to apply interventions, in the hope of patients becoming less difficult; on the other hand, problems in communication might hamper application of interventions. Any intervention applied by GPs on patients who are somatising according to these GPs, should therefore address communication problems.

The dichotomised GP-judgement 'somatising patient' corresponded in 77% of patients with the diagnosis 'DSM somatisation', in our study population of frequent attenders. This correspondence is high in comparison to a previous study<sup>12</sup> in patients with DSM somatisation, in which GPs rated main complaints as 'medically unexplained physical symptoms' in 38% of patients. The high percentages of somatisers and difficult patients among the frequent attenders in our study are flattered, since all frequent attenders with a DSM somatisation score of  $\geq 5$  were selected (N=462), whereas only a random sample (N=250) out of about 600 patients with a score of  $\leq 5$  were selected.

The findings on the second study question were surprising: in frequent attenders with at least 5 DSM somatisation symptoms, GP-judgement on somatisation hardly predicted any aspect of clinical course. This might be due partly to a limitation of this study: data on clinical course were available for trial participants only. This implies that conclusions on the predictive validity of GP-judgements, DSM and SCL somatisation symptom scores are limited to frequent attenders with five or more DSM somatisation symptoms. This is, however, a quite relevant population, in which the GP has to decide whether a patient is somatising or not. In open populations, or populations of consecutive visitors in general

practice, in which the predictive power of somatisation measures might be higher. As a second possible explanation for the low predictive power, we considered the relative instability of GP-judgement over time. However, SCL somatisation scores, which were more stable, did not predict clinical course better.

Our GPs had not received specific guidelines concerning recognition of somatisation. Although such guidelines do exist, their diagnostic and prognostic value is limited. Simple symptom counts have been developed as screening tests for somatisation disorder (7-item tests)<sup>13, 14</sup>, and for somatisation (16-item somatisation sub-scale of the 4DSQ)<sup>15</sup>. These screening tests correlate closely to the standardised SCL and DSM somatisation scales, but their relation to clinical status has not been assessed. Recent studies have shown that new cut-off points of existing lifetime-symptom lists yield enhanced correlation with cross-sectional clinical status<sup>16</sup>, but predictive power over a longer period has not been studied as yet. Moreover, recall of lifetime symptoms is inconsistent and unreliable.<sup>17</sup> Multidimensional diagnostic guidelines are being advocated, in which psychopathology, aspects of communication, disability and duration of symptoms are measured as well.<sup>18, 19</sup>. Cox<sup>20</sup> has developed a Scoring list Somatic Fixation (SSF), as an aid for GPs to recognise somatisation: 11 signals are listed, concerning the way in which patients cope with illness and problems, patient behaviour during consultations, and feelings which this behaviour evokes in the doctor. However, the SSF seems to be not concrete enough to serve as a diagnostic tool, and is not used widely.

## CONCLUSIONS

We conclude that GP-judgement on somatisation is not a worse, but also not a better diagnostic tool than standardised somatisation measures. We recommend that GPs use their continuous personal relationship with somatising patients to develop diagnostic criteria with more power to predict prognosis. Such guidelines for the recognition of somatisation in general practice should take in account physical and psychiatric symptoms, current and previous clinical course, illness behaviour, social support and aspects of doctor-patient communication. In a qualitative study, for instance with focus groups of GPs, diagnostic criteria might be concretised. Such a diagnosis of somatisation would enable GPs to select those frequent attenders who need help<sup>11</sup>.

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## Chapter 7

### **General discussion**

## **INTRODUCTION**

In this last chapter findings of our study are summarised and connected to the aim of the study. Methodological considerations are given, with specific attention to the evaluation and the generalisability of the trial results. Implications of the findings for general practice are discussed, and recommendations for future research are given.

## **AIM AND FINDINGS OF THE STUDY**

The aim of this study was to contribute to the treatment of somatising patients in general practice. We searched for a therapeutic approach, which would not only diminish health care utilisation, but also improve subjective health of somatising patients, and which could be applied by general practitioners during their regular surgery hours. Review of the literature revealed that a cognitive-behavioural approach was most promising: especially reattribution, a concise form of cognitive-behavioural therapy developed for application by general practitioners, had already received some experimental support as an early intervention for somatisation. We developed three modifications to adapt the reattribution model to longstanding somatisation including hypochondria. Feasibility for GPs appeared to be fairly good, although dealing with persistent illness worry remained difficult for GPs. In a randomised trial the modified reattribution model showed to be effective in improving subjective health, lowering sick leave and diminishing health care utilisation of somatising patients in general practice. In order to help GPs to select those somatising patients who need treatment most, we examined factors which might predict clinical course. In frequent attenders with abridged somatisation according to DSM-III-R criteria, clinical parameters at baseline only moderately predicted clinical course over two years moderately, and neither GP attendance, nor the GPs' judgement on somatisation or difficulty of the patient, nor stress-factors added substantially to this prediction.

## **METHODOLOGICAL CONSIDERATIONS**

In our study patient selection was performed by the research team. Intervention GPs received a list of up to 10 patients who were allocated to the reattribution condition, control

patients were not revealed to the GP. This procedure has several major advantages. (1) Intervention GPs can concentrate on their main task, which is performance of the intervention, without being bothered with odd jobs. (2) GPs were hardly aware which patients participated as controls, thus the usual care condition was not contaminated with special attention. (3) Last but not least, enrolment of a sufficient number of patients is guaranteed. The price to be paid for these advantages was that some of the patients selected did not somatise according to their GP. As a result, intervention GPs did not start reattribution in some of their intervention patients. Nevertheless the trial results reached significance. Had the results of the trial be less robust, a power problem might have been present.

The reattribution study formed a twin study, together with the disclosure study in Maastricht<sup>1</sup>. Two completely different interventions for patients with somatisation in general practice were studied simultaneously with identical definitions, operationalisations, selection criteria and measurement instruments. Thanks to the identical designs the results of the studies can easily be compared. A priori we hoped to be able to specify subgroups for which either disclosure, or reattribution would be the preferred approach. Unfortunately, disclosure showed no effect, neither overall, nor for specified subgroups, whereas reattribution appeared to be effective, without marked differences between subgroups. As a consequence, the detailed comparison of the interventions did not yield extra information.

A methodological infirmity of the reattribution trial is the 'fallacy of the wrong level': randomisation was necessarily performed on practice level to avoid contamination, whereas analysis was performed on patient level. Statistically, a larger number of practices with a smaller number of participating patients per practice is to be preferred. Analysis revealed small inter-practice variations within treatment groups, so outcome analyses were performed on patient level only. Multi-level analysis was not planned. Since 1995, when this trial was designed, multi-level analysis has gained importance in research in general practice. Had we designed the trial by now, we would have tried to enrol more practices, and planned multi-level analysis, to keep in line with recent developments. The small inter-practice variations, however, indicate that it is unlikely that results would be different. In the chapters four and five, the variable 'practice' was entered into the multivariate analyses after transformation into dummy variables. Here also, the role of inter-practice variations appeared to be small, in comparison to the role of other predictors.

## EVALUATION OF THE TRIAL RESULTS

Effects of reattribution two years after the start of the intervention were more marked than one year after the start. This is remarkable, because during the first year the GPs were coached in their performance of the intervention, whereas during the second year no support was given and GPs' performance in practice was not measured. The increase in effect during long-term follow-up is in contrast with medication studies on somatisation, and is in line with other studies evaluating CBT for different conditions<sup>2</sup>. Improvement of the reattribution group was impressive, while the control group remained stable on all outcome measures. As devil's advocate we put forward the question whether the results were really caused by the reattribution intervention. Did patients really go through a process of reattribution? Or could, for instance, Hawthorne effects (unspecific attention) have worked in favour of the intervention group? A Hawthorne effect seems probable, since the GPs have attended a training programme, feel more competent and will probably feel more drive to treat their somatisers well. Findings which argue against a Hawthorne effect, are (1) intervention patients did not spend more time with their GPs and even visited their GPs less frequently than control patients, (2) communication problems as reported by GPs did not subside in either group; GPs did not like intervention patients more after the trial period, and their scores on difficulty of the intervention patients did not change. The following indicators of the process of reattribution have been measured. The first stage of reattribution, feeling understood, is reflected in an increase in social support from the GP, reported by the intervention group only. In audio-taped consultations reattribution took place. In the intervention group, the percentage of patients who answer 'I don't know' on open questions after the cause of their symptoms, decreases in favour of psychic and psycho-somatic attributions. After all, the outcome in the intervention group can largely be ascribed to reattribution.

Although the intervention group improves to a clinically relevant degree, subjective health remains lower and medical consumption remains higher than in non-somatising patients. Reattribution does not 'cure' somatisation. For GPs, somatising patients remain difficult, frequently attending patients.

## GENERALISABILITY OF THE TRIAL RESULTS

Optimal generalisability would imply that every trained GP were able to apply the modified reattribution model to all somatising patients in her or his practice, with the same effects as we found in our trial. Regarding the GPs, doctors without interest in the treatment of somatisation will not have participated in the trial. This may have flattered our estimation of the feasibility of the reattribution model, as will discussed below, in the section on recommendations for practice. With regard to patients, we have tried to optimise generalisability by using comprehensive inclusion criteria with as little exclusion criteria as possible. Nevertheless, patients participating in the trial may differ from their counterparts in practice on relevant aspects, such as demographic characteristics.

Immigrants were underrepresented in this study: immigrants with insufficient knowledge of the Dutch language were unable to complete the postal screening questionnaire. Even immigrants with sufficient knowledge of the Dutch language had a lower response rate to the screening questionnaire than native Dutch patients, and they more often did not answer letters nor phone calls, resulting in a lower percentage giving informed consent. This is to be regretted, because several studies on different groups of immigrants report that somatisation is a major and highly prevalent problem.<sup>3, 4</sup>, due to psychological distress inherent to the immigrant or refugee condition<sup>5, 6</sup>. Perhaps, the participation rate of immigrants in our study would have been higher, if ethnic key figures had been involved to inform immigrants and to ask informed consent. Moreover, it is uncertain whether the reattribution model is acceptable for and effective in immigrants, since attribution of somatic symptoms to psychological causes is unusual in many parts of the world.<sup>7, 8</sup> We consider reattribution as Western 'product', which can not be exported all over the world.

Mostly women were included in the trial. On the one hand this may be due to the way in which patients were selected, on the other hand somatisation may be more prevalent in women. The first step of patient selection was detecting frequent attenders aged 20 to 45. In general practice men (except older men) are less likely to be frequent attenders: recently an Odds Ratio of 0.14 has been reported<sup>9</sup> Our second step was a postal screening questionnaire. In line with van den Akker, who reported that response-rates on questionnaires tend to be higher in women than in men<sup>10</sup>, women responded more frequently to our screening questionnaire than men, with a sex-ratio of 5:1 in responders versus 3:1 in non-responders.

The final step in patient selection, asking informed consent, revealed no sex-difference. In summary, our method of patient selection certainly favoured women. The question whether somatisation is more prevalent in women, cannot be answered strait-forwardly and depends partly on the definition of somatisation. While somatisation disorder according to DSM-III-R criteria (at least 12 symptoms in men versus 14 symptoms in women) is diagnosed about ten times as often in women than in men, sex differences disappear when a lower threshold of eight symptoms is applied.<sup>11</sup> Escobar<sup>12</sup> has proposed a threshold of four symptoms in men versus six in women, to account for the greater number of female versus male reproductive symptoms in the DSM-list, and for sex-differences in tendency to report somatic symptoms. We chose a threshold of five symptoms for both sexes, because we saw no reason why a women would suffer less from five reported symptoms than a man. This hypothesis was confirmed by our data, as can be seen from Table 1: men and women reporting five DSM-symptoms scored similarly on subjective health and medical consumption. Only the number of weeks sick leave from work or household was higher in men, a finding which may be biased because full-time housewives frequently skipped the question on absence from work.

**Table 1** Implications of somatisation on men versus women with 5 DSM somatisation symptoms. N=204

	Scale range	Men N=29 median (inter-quartile range)	Women N=175 median (inter-quartile range)
Subjective health	0-100	41 (24-57)	39 (23-69)
Medical consumption	0-	16 (11-20)	17 ( 8-30)
Sick leave in weeks	0-26	6 ( 4-23)	4 ( 2-12)

Our subjects were aged 20 to 45. Trial results can neither be extrapolated to youth, nor to elderly. Beyond the age of 45, chronic somatic diseases become more prevalent. Interaction between the process of somatisation and chronic disease will make it more difficult, both for GP and patient, to determine whether a symptom is indicative for somatisation or for disease. Old age in itself should not be a reason to refrain from applying reattribution, since good results are reported from cognitive-behavioural interventions in the elderly.<sup>13</sup>

Our study population represented the broad spectrum of somatisation seen in general practice: from mild to severe, including longstanding somatisation, hypochondria, and

somatising patients with depression or anxiety disorders. Only patients who had recently started to somatise were not eligible for this study. Reattribution, however, had already shown to be effective in this early stage of somatisation<sup>14</sup>, so we conclude that the results of our trial apply to all sub-types of somatisation.

Level of education of patients did not influence results. Apparently GPs were able to be on the same wavelength. Nevertheless GPs should be alert on illiteracy, and offer alternative ways of diary-keeping.

## **IMPLICATIONS AND RECOMMENDATIONS FOR GENERAL PRACTICE**

What can GPs gain by learning and applying the reattribution model? From the trial we can conclude that the reattribution model offers an effective therapeutic tool for GPs, which can induce favourable changes in clinical course in somatising patients. Nevertheless most patients remain frequent attenders, who are often experienced by their GPs as difficult, and will probably need repetitive 'reattribution boosters'. For GPs who hope and expect that reattribution might normalise patients' illness behaviours, these results may be disappointing. Perhaps patients gain more from reattribution than their GPs. Realising this, in turn, may stimulate GPs to learn and apply reattribution.

What is required from GPs who learn and apply reattribution? Firstly, reattribution requires a genuine interest in the patients' ideas about their symptoms, and willingness to give the floor to the patients' story. This may be difficult if a troubled doctor-patient communication has developed. GPs should be willing to invest energy in their relation with somatising patients. Moreover, learning to apply reattribution requires considerable time investment from GPs. Application in practice, however, is time-neutral, and may even save time in the long term: longer consultations are outweighed by a lower frequency of attendance. However, we found that duration of the reattribution consultations showed considerable variation, with a range from ten to 30 minutes, and duration could be measured only in the small proportion of consultations which were audio-taped. Conclusions about time investment should therefore be interpreted with caution.

To which patients should GPs apply reattribution? In chapter five we conclude that those patients in whom somatisation strongly affects health and markedly increases medical consumption, especially if they report a lack of social support, are most in need of intervention. Reattribution appeared to be as effective in this subgroup as in less severely



affected patients, so it seems wise that GPs apply reattribution to this severe group with priority. A warning seems appropriate: GPs who start to apply the newly learned reattribution techniques, should not immediately apply them to their most difficult heart sink patients. Reattribution is better practised first with ‘part somatisers’, who do not feel misunderstood so profoundly, and who are to some extent open to broadening of the agenda.<sup>15</sup>

## RECOMMENDATIONS FOR RESEARCH

Our trial was the first randomised clinical trial with reattribution for somatisation in general practice. We think the results need replication in further trials in other countries, in older patients, in immigrant groups.

Courses on reattribution for GPs should be evaluated systematically, with special attention to time investment and determinants of feasibility. Feasibility of reattribution in immigrants, especially from non-western cultures, should be studied with attention to degree of acculturation and culturally determined disease concepts and illness behaviours. In studies in which immigrants are to be included, it may be worthwhile to involve ethnic key persons to inform immigrants and to ask for informed consent.

GP-judgement on somatisation hardly predicts clinical course in frequent attenders. More research is needed to evaluate whether a more educated judgement on somatisation (for instance with a combination of a short screening instrument as is currently being developed <sup>16</sup>, in combination with their judgement on aspects of communication predicts clinical course better.

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## Summary

Chapter one describes background and aim of the thesis. The study aims to contribute to more effective treatment of somatising patients in general practice. Reattribution is introduced, as treatment to be evaluated. This study is closely related to a sister-study performed in Maastricht by Bert Schilte, in which disclosure is evaluated as treatment for somatisation in general practice. The studies used identical criteria for patient selection, and measurement instruments, had a synchronic time-scheme, and made use of each other's data.

Chapter two reports on a systematic review into the effectiveness of treatments for somatisation in general practice. Ten randomised trials were included. A psychiatric consultation letter to the GP decreased health care utilisation without influencing the patient's health. Medicines hardly showed any effect. A cognitive-behavioural approach improved health and decreased health care utilisation. No randomised trial was found in which cognitive-behavioural treatment is performed by GPs.

In chapter three the development of the reattribution intervention is described, and feasibility in general practice is evaluated. Reattribution has been developed by Goldberg and Gask in 1989, as a cognitive-behavioural treatment for somatisation. Reattribution has three stages: making patients feel understood, broadening the agenda from somatic complaints to psychosocial issues as well, and finally making a link between the patient's distress and the physical complaints. We developed three modifications: dealing with persistent illness worry, adjustment of the doctor's speed to that of the patient, and the use of symptom diaries. Ten GPs attended a 20-hour training programme, one of them dropped out. Application of reattribution in practice required on average three consultations of 10 to 30 minutes' duration. Dealing with persistent illness worry remained difficult to perform for the GPs.

Chapter four describes the randomised controlled trial on effectiveness of reattribution in general practice. Frequent attenders with five or more somatisation symptoms according to DSM-III-R criteria were eligible. In nine control practices 87 patients received usual GP care, while 75 patients in eight intervention practices (with 10 GPs) were assigned to the reattribution condition. GPs actually applied reattribution to 51 patients. At baseline and 6, 12 and 24 months later, patients reported questionnaires on the outcome measures; complete

follow-up was available from 92% of patients. At 24 month follow-up the reattribution group showed major and statistically significant improvement, compared to the control group which remained unchanged. Subjective health increased from median 30/100 to 74/100. Health care visits decreased from median 10 to 5 per 6 months, while the use of medicines remained unchanged. Sick leave diminished from median 5 to 0 weeks per 6 months. Visits to GPs diminished in the reattribution group only. Depression, anxiety disorder and hypochondria did not influence the effects of reattribution.

Chapter five describes the clinical course of somatisation in general practice, during a two-year period in 376 patients, and the role of stressors as predictors of clinical course. Overall, the outcome measures (subjective health, sick leave, health care visits, and use of medicines) remained stable in the total group of patients over two years. Chronic difficulties and life events were strong cross-sectional indicators of outcome. Only social support predicted one- and two-year outcome. We are far from being able to predict which somatising patients will become progressively disabled or dependent on health care. When selecting somatising patients who need treatment most, GPs should focus on patients with impaired subjective health and high medical consumption, especially those who lack social support.

Chapter six focuses on the GP-judgement on somatisation: which frequent attenders are judged as somatisers, which are judged as difficult patients, and what is the predictive value of the GP-judgements for clinical course? Fifteen GPs assessed 713 frequent attenders on somatisation and aspects of doctor-patient communication. Frequent attenders who ask superfluous examinations or treatments and who behave helplessly according to their GP, are more likely to be labelled as somatising patient; 73% of the somatisers were judged as difficult patient, especially those who the GP likes less. In trial participants, neither the GP-judgement on somatisation, nor standardised somatisation measures (DSM-III-R, SCL somatisation scale), contributed substantially to a prediction of clinical course over two years.

In chapter seven key conclusions and recommendations are discussed. Reattribution improves clinical course in somatising patients, and is feasible in general practice. Further research should focus on feasibility and effectiveness of reattribution in elderly and immigrants, on feasibility of our modification 'dealing with persistent illness worry', and on the required time investment of GPs. Since GPs judge the majority of somatisers as 'difficult patient', courses on somatisation should address the doctor-patient relationship.

# Samenvatting

Dit proefschrift gaat over somatiserende patiënten: mensen die vaak naar de dokter gaan met hardnekkige of wisselende lichamelijke klachten, zonder dat lichamelijke ziekte een verklaring voor de klachten vormt. Somatisatieklachten wordt vaak in verband gebracht met psychische of sociale problemen, nu of in het verleden. Het verschil met het begrip psychosomatische klachten is, dat daarbij wel een aantoonbare ziekte aanwezig is, waarvan men dan aanneemt dat die mede door psychische factoren veroorzaakt is. Letterlijk betekent somatiseren “verlichamelijken”, en in zijn meest gewone vorm zal iedereen het verschijnsel kennen: spanning, emoties, onvrede worden vaak lichamelijk gevoeld, bijvoorbeeld als buikpijn, moeheid, rugpijn, duizeligheid, een brok in de keel, ademtekort. Somatiseren kan een probleem worden als de klachten aanhouden, een eigen leven gaan leiden, het normale leven verstoren, en ongerustheid veroorzaken. De relatie tussen patiënt en arts kan vastlopen: patiënten zijn ziek en voelen zich miskend door hun dokter die geen ziekte kan vinden en hen vast een aansteller vindt, terwijl dokters zich machteloos gaan voelen of ergeren aan de patiënt die steeds terugkomt met ‘niets’, die zich niet laat geruststellen en blijft aandringen op onnodig onderzoek en verwijzing. Het doel van dit proefschrift is bij te dragen aan een betere benadering van somatiserende patiënten door de huisarts.

In hoofdstuk één worden achtergrond en doelstelling van het proefschrift beschreven. De keuze voor reattribution als te onderzoeken behandeling wordt onderbouwd. De studie beschreven in dit proefschrift is nauw verbonden met het promotieonderzoek van Bert Schilte in Maastricht, waarin de effectiviteit van disclosure als behandeling voor somatisatie wordt geëvalueerd. Selectie van patiënten, meetinstrumenten en tijdpad zijn identiek, en de studies maken gebruik van elkaars data.

In hoofdstuk twee wordt door middel van een systematisch literatuuronderzoek nagegaan wat er bekend is over de effectiviteit van behandelingen voor somatisatie in de huisartspraktijk. Tien gerandomiseerde onderzoeken worden besproken. Psychiatrisch advies door middel van een brief aan de huisarts leidt er toe dat patiënten minder beroep doen op de gezondheidszorg, maar zij gaan zich niet beter voelen. Van medicijnen is weinig effect aangetoond. Een cognitief-gedragsmatige aanpak verbetert de gezondheid en vermindert het

gebruik van gezondheidszorg, maar uitvoering door de huisarts is niet gerandomiseerd onderzocht.

In hoofdstuk drie wordt de reattributie behandeling beschreven en wordt de haalbaarheid in de huisartspraktijk geëvalueerd. Reattributie is een cognitief-gedragsmatige aanpak, ontwikkeld door Goldberg en Gask, waarmee de huisarts somatiserende patiënten stimuleert de klachten te gaan toeschrijven aan andere oorzaken dan lichamelijke ziekte. De patiënt doorloopt drie stappen: zich serieus genomen voelen, verbreding van de agenda, en tenslotte het leggen van verband tussen klacht en leefsituatie. Wij brachten drie wijzigingen in het reattributiemodel aan: huisartsen brengen niet te snel hun eigen interpretatie van de klachten naar voren, patiënten houden een klachtendagboek bij, en bij patiënten met hardnekkige ongerustheid gaat de huisarts dieper in op de meest alarmerende gedachte. Tien huisartsen, van wie er één uitviel, volgden 20 uur reattributietraining. Het toepassen in de praktijk kost per patiënt gemiddeld drie consulten van 10 tot 30 minuten. Het ongerustheidsbeleid wordt weinig toegepast, de huisartsen vinden het moeilijk.

In hoofdstuk vier wordt het gerandomiseerd gecontroleerde onderzoek naar de effectiviteit van reattributie in de huisartspraktijk beschreven. Veelkomende patiënten die minstens vijf somatisatieklachten hadden (nu of in het verleden) volgens DSM-III-R criteria, konden aan het onderzoek meedoen. In 9 controlepraktijken ontvingen 87 controlepatiënten de gebruikelijke zorg van hun huisarts, in 8 interventiepraktijken (met 10 huisartsen) werden 75 patiënten aangewezen als interventiepatiënt. Bij 51 van hen paste de huisarts feitelijk reattributie toe. Bij de start van het onderzoek, en na 6, 12 en 24 maanden vulden de patiënten vragenlijsten in over de uitkomstmaten. Door 92% van de patiënten werden alle vragenlijsten ingevuld. In vergelijking tot de controlegroep die onveranderd blijft, is de interventiegroep na twee jaar sterk en statistisch significant verbeterd: de ervaren gezondheid stijgt van mediaan 36/100 naar 74/100, het aantal bezoeken aan hulpverleners daalt van mediaan 10 naar 5 per halfjaar en het aantal weken ziekteverzuim zakt van mediaan 5 naar 0, echter het medicijngebruik blijft gelijk. Alleen in de interventiegroep daalt het aantal bezoeken aan de huisarts. Depressie, angststoornis of hypochondrie beïnvloeden het effect van reattributie niet.

In hoofdstuk vijf wordt het beloop van somatisatie in de huisartspraktijk beschreven gedurende een periode van twee jaar, bij 376 somatiserende patiënten: de klinische toestand (ervaren gezondheid, bezoek aan hulpverleners, medicijngebruik en ziekteverzuim) blijft

gemiddeld stabiel. Verder wordt gekeken of stressfactoren (chronische moeilijkheden, levensgebeurtenissen, gebrek aan sociale steun, traumatische jeugdervaringen) het beloop van somatisatie kunnen voorspellen. Chronische moeilijkheden en levensgebeurtenissen blijken sterk samen te hangen met de klinische toestand op datzelfde moment, maar voorspellen bijna niet hoe het met de patiënten gaat na één of twee jaar. Alleen de factor sociale steun voorspelt hoe het met de patiënten gaat in de eerste twee jaar. Als huisartsen onder hun somatiserende patiënten diegenen willen selecteren die dringend behandeling nodig hebben, kunnen ze hun hulp het best richten op patiënten die hun gezondheid als slecht ervaren, die een hoog medicijngebruik hebben en die weinig sociale steun ervaren.

Hoofdstuk zes gaat over het oordeel van de huisarts: welke veelkomende patiënten noemt de huisarts somatiseerder, welke veelkomers worden beoordeeld als moeilijke patiënt, en in hoeverre voorspellen beide huisartsoordelen het klinisch beloop? Vijftien huisartsen beoordeelden in totaal 713 veelkomende patiënten met betrekking tot somatisatie en aspecten van arts-patiënt communicatie. Veelkomers die overbodige onderzoeken of behandelingen eisen en die zich hulpeloos opstellen volgens hun huisarts, worden vaker als somatiseerder benoemd. De huisarts beschouwt driekwart van deze somatiseerders als moeilijke patiënt, met name diegenen die hij of zij niet aardig vindt. Bij de somatiserende patiënten die deelnamen aan de Amsterdamse en Maastrichtse interventie onderzoeken, voorspelt het huisartsoordeel over somatisatie het klinisch beloop over twee jaar niet.

De belangrijkste conclusies en aanbevelingen van dit proefschrift zijn: reattributie verbetert het klinisch beloop bij somatiserende patiënten en is toepasbaar voor de huisarts. Nader onderzoek is gewenst naar de haalbaarheid en effectiviteit van reattributie bij ouderen en allochtonen, naar de toepasbaarheid van het onderdeel 'beleid bij hardnekkige ongerustheid', en naar de tijdsbelasting voor de huisarts. Aangezien huisartsen het merendeel van de somatiseerders beoordelen als moeilijke patiënten, dient in nascholing over somatisatie aandacht besteed te worden aan de arts-patiënt relatie.

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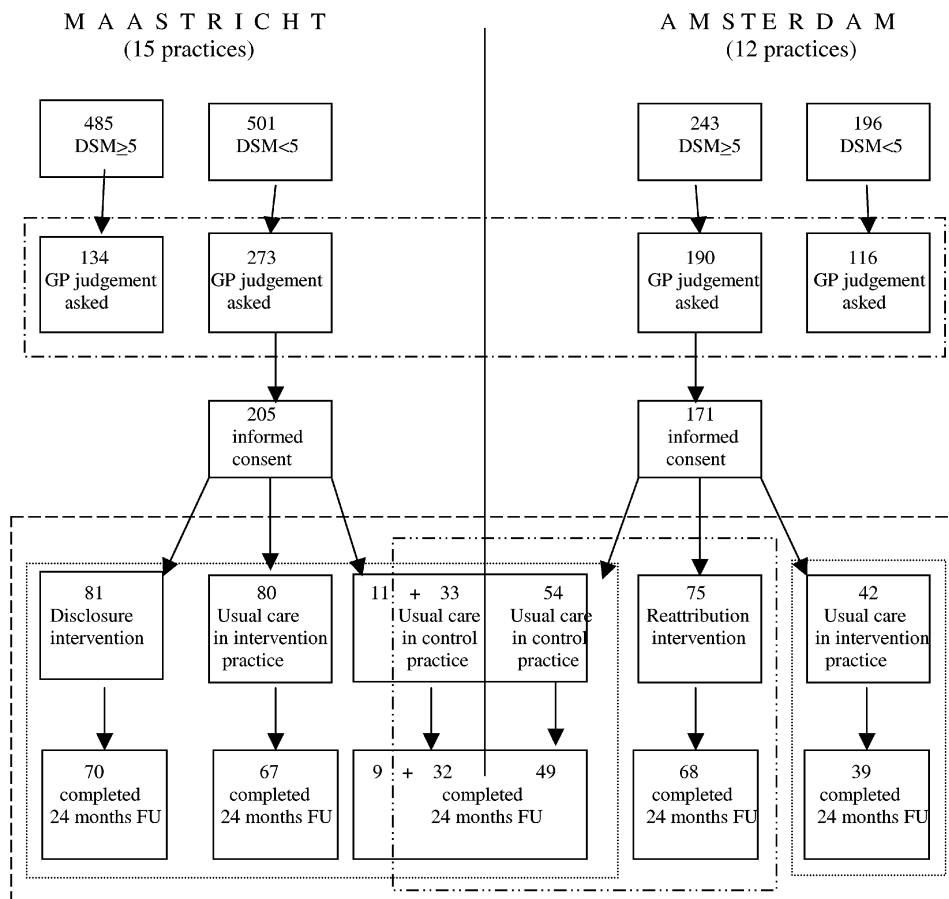
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# Appendix A

## STUDY PROFILE: PATIENTS PER CHAPTER



# Appendix B

## MEASURES

### MAIN OUTCOME MEASURES

Medical consumption	
- N of visits to all health care	'Uw Klachten' <sup>a</sup> question 8
- N of visits to GP	Patient records in general practice
- N of different medicines	'Uw Klachten' <sup>a</sup> question 10
Subjective health	
- current symptoms (last month)	'Uw Klachten' <sup>a</sup> question 1
- impact current symptoms on daily life	'Uw Klachten' <sup>a</sup> question 3
- ruminating about current symptoms	'Uw Klachten' <sup>a</sup> question 4
- quality of health	'Uw Klachten' <sup>a</sup> question 6
Sick leave	'Uw Klachten' <sup>a</sup> question 9

### SOMATISATION MEASURES

Somatisation	DSM-III-R somatisation <sup>a</sup> [Am.Psychiatr.Ass.1987]
	SCL somatisation scale <sup>a</sup> [Derogatis 1977]
	GP judgement on somatisation

### SYMPTOM ATTRIBUTIONS AND ILLNESS ATTITUDES

Causal attributions current symptoms	'Uw Klachten' <sup>a</sup> question 2
Illness attitudes	Illness Attitude Scales <sup>a</sup> [Kellner 1987]
Somatisation according to patient	'Uw Klachten' <sup>a</sup> question 11, 12

### DOCTOR-PATIENT COMMUNICATION

Support from GP	Social network list: questions about GP <sup>a</sup>
Problems in communication	GP judgement on communication

### STRESSORS

Lack of social support	Social network list <sup>a</sup>
N of Life events	Life events list <sup>a</sup>
Chronic difficulties (N and severity)	Groningse lijst langdurige moeilijkheden
Problems in childhood	Youth experiences questionnaire [Portegijs 1996]

### OTHER MEASURES

Quality of life	'Uw Klachten' <sup>a</sup> question 5
Depression	SCL Depression scale <sup>a</sup> [Derogatis 1977]
Anxiety disorders	SCL Anxiety and Agoraphobia scales <sup>a</sup> [Derogatis 1977]
Demographical data	Demographical questionnaire <sup>a</sup>
Coping styles	Utrechtse Coping Lijst <sup>a</sup>

### PERFORMANCE OF REATTRIBUTION BY GP

Performance of reattribution	Self-registration form for each consultation
	Audiotapes of consultations
Evaluation	Semi-structured interviews with GPs

a. Postal patient questionnaire, see Appendix C

# Appendix C

## PATIENT QUESTIONNAIRE ON MAIN OUTCOME VARIABLES

### UW KLACHTEN

- 1 Welke klacht of klachten heeft u de afgelopen maand gehad? (bij meer klachten: belangrijkste drie klachten noemen)  
Kunt u in een paar woorden opschrijven wat u precies voelt als u last heeft van de klacht.

1<sup>e</sup> klacht: .....

2<sup>e</sup> klacht: .....

3<sup>e</sup> klacht: .....

De volgende vragen gaan over de klachten die u in vraag 1 over de afgelopen maand heeft genoemd.
--

- 2 Wat is volgens u de oorzaak van de klachten?

1<sup>e</sup> klacht: .....

2<sup>e</sup> klacht: .....

3<sup>e</sup> klacht: .....

- 3 Hoeveel invloed hebben uw klachten **de afgelopen maand** op de volgende onderdelen van uw dagelijks leven (zet voor ieder onderwerp een kruisje op de lijn):

- 3a uw werk:

helemaal niet heel sterk

|-----|

- 3b uw slaap:

helemaal niet heel sterk

|-----|

- 3c sport/lichaamsbeweging:

helemaal niet heel sterk

|-----|

3d omgang met familie en vrienden:

helemaal niet heel sterk

|-----|

3e uw stemming:

helemaal niet heel sterk

|-----|

4 Zit u veel over uw klachten te denken of te piekeren?

helemaal niet heel sterk

|-----|

5a Zoals veel mensen een idee kunnen hebben over de kwaliteit van dingen, zo kunnen ze ook een idee hebben over de **kwaliteit van hun leven**. Deze kan goed of slecht zijn of er ergens tussenin. Wilt u op de lijn hieronder aangeven waar u vindt dat **nu** de kwaliteit van uw leven ligt?

erg slecht erg goed

|-----|

5b Was de **kwaliteit van uw leven** 6 maanden geleden slechter of beter dan nu?

veel slechter veel beter

|-----|

6a Wilt u op de lijn hieronder aangeven hoe **gezond** u zich de afgelopen maand voelde. Het gaat om de **gezondheid zoals u die ervaart**.

niet gezond heel gezond

|-----|

6b Was uw **gezondheid zoals u die ervaart** 6 maanden geleden slechter of beter dan nu?

veel slechter veel beter

|-----|



- 7a Bent u de **afgelopen 6 maanden** met nieuwe activiteiten begonnen?  
Zo ja, met wat:
- sport, welke: .....  
hobby, welke: .....  
werk, welk: .....  
cursus/opleiding: .....  
niet met nieuwe activiteiten begonnen
- 7b Bent u de **afgelopen 6 maanden** met nieuwe activiteiten gestopt, zoals sport, studie, hobbies, interessen of werk?  
Zo ja, met wat:
- sport, welke: .....  
hobby, welke: .....  
werk, welk: .....  
cursus/opleiding: .....  
niet met activiteiten gestopt
- 8 Bent u de **afgelopen 6 maanden** bij de volgende hulpverleners geweest en hoeveel keer bent u er geweest? (als de hulpverlener bij u kwam telt dat ook mee).
- |   |            |
|---|------------|
| eigen huisarts:                               | ..... keer |
| andere huisarts:                              | ..... keer |
| medisch specialist, welk specialisme?         |            |
| 1 .....                                       | ..... keer |
| 2 .....                                       | ..... keer |
| 3 .....                                       | ..... keer |
| fysiotherapie, mensendieck- of cesartherapie: | ..... keer |
| dietiste:                                     | ..... keer |
| maatschappelijk werk:                         | ..... keer |
| psycholoog, psychotherapeut of RIAGG:         | ..... keer |
| alternatieve genezer, welke: .....            | ..... keer |
| andere hulpverlener, welke: .....             | ..... keer |
| niet bij hulpverleners geweest                |            |
- 9 Hoeveel weken heeft u de **afgelopen 6 maanden** niet gewerkt wegens ziekte (huishouden telt ook als werk)?
- ..... weken
- 10 Welke medicijnen heeft u de **afgelopen 6 maanden gedurende een periode langer dan een week** gebruikt? Alle medicijnen tellen mee, ook die u zelf gekocht heeft. Indien u zich de naam van het middel niet herinnert, schrijft u dan op waarvoor u het gehad heeft.
- kalmeringsmiddelen: .....  
slaapmiddelen: .....  
pijnstillers: .....  
vitamines: .....  
homeopathische middelen: .....  
andere middelen: .....

# Appendix D

## **‘REATTRIBUTION’ AND ‘DEALING WITH PERSISTENT HEALTH ANXIETY’ Text for intervention GPs [in Dutch]**

### **1 REATTRIBUTIETECHNIEK**

#### **1.1 Wat is reattribution**

Re-attributie betekent letterlijk: her-toeschrijven. Somatiserende patienten schrijven klachten en lichamelijk onwelvoelen al snel toe aan ziekte, ook bij klachten waar jij als huisarts bijvoorbeeld denkt aan overbelasting, stress, gewone fysiologische oorzaken en dus niet aan ziekte. Reattribution is een techniek die de huisarts toe kan passen, waarmee de huisarts de patiënt maximaal stimuleert om ook andere oorzaken te overwegen dan ziekte. Het gaat er uitdrukkelijk niet om dat de huisarts de patiënt trekt naar de richting waarin de huisarts zelf de oorzaak ziet, maar om het oppikken van elke uiting van de patiënt, die erop wijst dat de patiënt ook aan andere dan ziekte-oorzaken denkt. Ook een piepkleine aanzet verdient stimulering. De huisarts mag bekrachtigen, afremmen, sturen, zolang hij/zij maar gebruik blijft maken van de energie van de patiënt. De patiënt moet harder werken dan de huisarts.

#### **1.2 Hoe gaat reattribution in zijn werk; drie stappen**

Goldberg en Gask hebben in de tachtiger jaren de reattributionstechniek ontwikkeld en uitgewerkt tot een scholingspakket voor huisartsen en huisartsen-in-opleiding.[Goldberg 1989] In deze scholing leren huisartsen hoe ze, in drie stappen, hun patiënten tot reattribution kunnen brengen.

<u>Stap</u>	<u>Doel</u>	<u>Middelen</u>
1. zich begrepen voelen	versterken van vertrouwensbasis	- dóórvragen op klachten - alert zijn op emoties en klachtinterpretatie - aandachtig lichamelijk onderzoek - dagboek
2. agenda verbreden	gegevens verzamelen patiënt activeren	- uitleg lichamelijk onderzoek - klacht als reëel benoemen - benoem emoties + klachtinterpretaties - dagboek
3. link leggen	feitelijke reattribution	- dagboek bespreken - uitleg 'link' - 'link' demonstreren

Op de drie reattributiestappen gaan we nu nader in, met nadruk op punten waarin de reattributietechniek verschilt van gewone goede consultvoering.

### **Stap 1. Zich begrepen voelen**

Dit houdt in dat je de patiënt serieus neemt, zodat hij/zij zich begrepen voelt. Dat klinkt bekend: hebben wij niet uit den treure geleerd hoe belangrijk een goede intake is, zeker bij 'vage klachten'? Toch is er verschil. Wij zijn erin getraind iemand serieus te nemen door gevoel te reflecteren, het Rogeriaanse hummen hebben velen tot in het karikaturale meegekregen. Overigens is dit een achterhaald beeld van de Rogeriaanse methode: actief luisteren houdt tegenwoordig ook in dat je actief doorvraagt in het spoor van de patiënt. Bij somatiseerders is actief doorvragen over de klacht essentieel. Vraag méér feiten, ga op de klacht in zoals je doet bij een somatische alarmklacht: waar/ wanneer/ karakter van de pijn, enzovoorts. Dus concretiseer! Nodig de patiënt uit nog meer over de klachten te vertellen. Dit hebben huisartsen soms afgeleerd uit angst daarmee somatische fixatie te versterken. Veel somatiseerders krijg je echter pas mee als ze 'verzadigd' zijn van het mogen vertellen over de klacht. Een ellenlang consult is daarbij niet nodig: na 10 minuten kun je een dagboek-opdracht introduceren (zie onder).

Doe altijd gericht lichamelijk onderzoek. Zowel omdat je pas als je zelf op somatisch gebied een pluisgevoel hebt rustig aan reattributie kunt werken, als om de patiënt serieus te nemen. Doe geen haastig flutonderzoekje maar werk nadrukkelijk aandachtsvol. Vergelijk het maar met het kijken in je spiegelkje op het rijexamen: niet alleen kijken maar ook laten zien dat je gekeken hebt.

### **Stap 2. Verbreden van de agenda**

Het doel is om niet alleen lichamelijke klachten gespreksonderwerp te laten zijn. Oorspronkelijk sprak Goldberg van 'changing the agenda', maar dat gaf teveel de indruk dat het lichamelijke spoor van de agenda af moest. Dit is juist een valkuil waar wij als huisarts sterk geneigd zijn in te trappen: als we zelf het somatische spoor als doodlopend beschouwen zijn we zo blij als de patiënt bereid is op het emotionele spoor in te gaan, dat we liefst nooit meer naar het somatisch spoor terugkeren. Maar daarmee verliezen we de coöperatie van de patiënt: "als je tegen die dokter zegt dat je stress hebt kijkt hij je niet eens meer na". Houd dus consequent het tweesporenbeleid vol.

Leg je bevindingen van het lichamelijk onderzoek in positieve termen uit: dus niet 'niks gevonden' (als je niks vindt moet je immers beter zoeken), maar 'normale harttonen, regelmatige hartslag'. Pas op voor termen die de patiënt kan opvatten als ziekte, bijvoorbeeld 'blokkering' of 'aangeboren scheefstand'.

Bevestig dat de klacht reëel is. Weliswaar zul je vaak met de patiënt van mening verschillen over de interpretatie van de klacht, dit laat echter onverlet dat je de klacht zelf serieus neemt. Als een patiënt zegt dat hij vreselijke, bonzende hoofdpijn heeft dan is dat zo. Patiënten, ook veelkomende somatiseerders, zijn al gauw bang dat de dokter hen aanziet voor een aansteller of zeur. Dit gevoel is geen basis voor een goede werkrelatie.

*Het dagboek* Bij alle drie de reattributiestappen staat als middel het dagboek genoemd. Hieronder wordt verstaan dat de huisarts aan de patiënt vraagt een dagboek over de klachten bij te houden. Binnen de reattributietechniek dient het dagboek de volgende doelen. Allereerst bevestigt het dat jij de

klachten serieus neemt (reattributiestap 1). Ten tweede levert een dagboek materiaal over levensomstandigheden, emoties en interpretaties van de patiënt en maak je ermee duidelijk dat er over dit soort zaken met jou te praten valt (reattributiestap 2). Dit vat je straks samen als overgang naar reattributiestap 3, de feitelijke reattributie, het leggen van de link tussen lichamelijke klachten en stressfactoren. Soms begint een patiënt tijdens het bijhouden van het dagboek zelf al een verband tussen klachten en stressfactoren te zien, dan gaat reattributiestap 3 vanzelf.

Hoe breng je het dagboek ter sprake? Als het consult 10 minuten bezig is kun je bijvoorbeeld zeggen: "Een consult is te kort om alles te vertellen. U hebt al een heleboel over uw buikpijn verteld, u hebt er veel last van, ik vind het een belangrijk probleem. Waar we samen nog niet uit zijn, is onder welke omstandigheden de pijn optreedt. Wilt u komende week uw klachten eens opschrijven en ook uw gedachten daarbij? U noemde al dat u merkte dat de buikpijn erger is als u haast hebt en ook dat u bang bent voor een darmverkleving, misschien komen er in de loop van de week nog meer gedachten over uw buikpijn op".

Geef een papier mee met 3 kolommen:

<i>Ernst klacht:</i>	<i>Bezigheden</i>	<i>Gedachten over de klacht</i>
0% <span style="margin-left: 100px;">100%</span>		
<div style="border-top: 1px solid black; width: 100%;"></div>		

Het is handig hiervoor altijd lege A4tjes bij de hand te hebben, die je tijdens het consult indeelt. Je kunt dan de termen laten aansluiten bij datgene wat de patiënt al genoemd heeft. Houd niet te strikt vast aan de titels van de drie kolommen. Soms kun je bijvoorbeeld beter de frequentie van een klacht laten scoren dan de ernst. Heeft een patiënt net verteld dat hij veel vermijdt door de klachten, dan zul je misschien in de tweede kolom 'vermeden activiteiten' laten noteren.

Bij iemand bijvoorbeeld die steeds angstig oplet of zijn hart overslaat, kan de indeling er als volgt uitzien:

<i>Aantal keer op hartslag gelet</i>	<i>Waar was u op dat moment mee bezig?</i>	<i>Wat dacht u dat het op z'n ergst kon zijn?</i>
--	--	---

Iemand die elke middag hoofdpijn krijgt en dan naar huis gaat, kan bijvoorbeeld invullen:

<i>Hoe erg was de pijn op het ergste moment</i>	<i>Bezigheden op dat moment</i>	<i>Akties n.a.v. de klacht</i>
---	-------------------------------------	--------------------------------

Bedenk met de patiënt op welk moment hij/zij het dagboek gaat invullen, bijvoorbeeld 's avonds, of op het moment dat de klacht optreedt, of driemaal per dag. Spreek tevoren af hoeveel dagen de patiënt het dagboek gaat bijhouden. Meestal zal 1-2 weken voldoende zijn, dit is afhankelijk van de frequentie/ fluctuatie van de klacht. Benadruk dat voor het ontdekken van een patroon in het klachtenbeloop het noteren van 'goede dagen' even belangrijk is als het invullen op 'slechte momenten'. Vraag de patiënt het dagboek op de dag voor het volgende consult bij je in de brievenbus te doen, zodat je het tevoren kunt lezen. Doe dit ook en streep aan wat je opvalt.

### **Stap 3. De link leggen**

De derde reattributiestap houdt in dat de patiënt verband gaat leggen tussen klacht en stressfactor (emotie, levensgebeurtenis). Het bijzondere is eigenlijk dat je zolang wacht met het over een verband tussen klacht en emotie/levensgebeurtenis te hebben. Betrap jezelf er maar eens op hoe vaak je al binnen 5 minuten oppert of er verband is met stress/spanning/angst/drukke... Bij somatiseerders loop je daarmee dood, die trekken zich dan terug op het somatische spoor. De kern van de reattributietechniek is dat het er niet om gaat dat jij jouw link ziet/ benoemt, maar dat je de patiënt maximaal stimuleert om zelf een link te gaan zien. Daarvoor is nodig dat je jezelf ervan weerhoudt 'voor de patiënt uit te lopen'. Bij de bespreking van het dagboek zul je allereerst de patiënt vragen wat hem/haar opvalt, en daarbij aansluiten. Soms legt de patiënt zelf een link tussen klacht en stressfactor en ben je klaar. Anders geef je nu je eigen observaties, en vraagt de patiënt om commentaar. Ook daaruit kan een link volgen. Pas daarna opper je eventueel je interpretatie, altijd met de vraag of de patiënt er iets mee kan. Volgt ook hieruit geen link, stop dan. De patiënt staat nu niet open voor het zien van verband tussen zijn klacht en een achterliggende stressfactor. Er is overigens niets op tegen om dit traject later met een andere klacht opnieuw af te leggen.

*Uitleg link* Als de patiënt, hoe aarzelend ook, een verband ziet tussen zijn klacht en een stressfactor, kun je dit versterken door erop aansluitende uitleg over hoe deze stressfactor tot deze klacht kan leiden. Elke huisarts heeft daarvoor een eigen repertoire. Bijvoorbeeld:

- \* angst => spanning in de nekspieren => hoofdpijn
- \* angst ontregelt het autonome zenuwstelsel, wat leidt tot trillen, zweten, flauwvallen, enzovoorts
- \* in een depressieve stemming voel je je pijn erger en door de pijn ga je je zorgen maken dat je ziek bent.

Zoals te zien is in deze voorbeelden, gaat je uitleg in drie stappen: van de emotionele toestand, via een fysiologisch mechanisme, naar het somatische symptoom.

*Demonstratie link* Minder gebruikt maar vaak effectief is het om te demonstreren hoe de route van stressfactor naar klacht verloopt. Laat iemand maar eens enkele minuten de schouders een paar millimeter optrekken, dan voelt hij zelf zijn spierpijn opkomen. Ook hyperventilatieprovocatie is een voorbeeld. Soms zijn uit het dagboek demonstraties te halen, bijvoorbeeld een tijdsrelatie tussen stressmomenten en klachten.

*Identificatie* Deze techniek staat niet in het schema vermeld, omdat deze slechts bij een kleine groep patiënten te gebruiken is. Soms identificeert een patiënt zich sterk met iemand in de omgeving die dezelfde klacht had en bijvoorbeeld kanker bleek te hebben. De link klacht - kanker ligt dan voor de hand. Nodig de patiënt uit verschillen tussen hemzelf en de identificatiefiguur te zoeken. Als de patiënt iemand kent die dezelfde klachten kreeg o.i.v. stress, kun je identificatie juist goed aanmoedigen.

### **1.3 Agenda voor consulten**

Probeer niet alle drie de reattributiestappen in één consult te proppen. Meestal is spreiden over twee of drie consulten beter. Drie keer 10 à 15 minuten levert meer op dan één keer drie kwartier.

Haal je, voordat de patiënt binnenkomt, even voor de geest waar je met deze patiënt ook al weer mee bezig was. Los van de inhoud werkt het al goed dat je een plan hebt dat jezelf houvast geeft, waardoor je met meer zin aan het consult begint.

#### 1.4 Samenvatting

Tot slot van dit hoofdstuk zetten we de kernpunten nog even op een rij.

Somatiseren verloopt via 4 (denk)stappen:

- A sterk de aandacht richten op het eigen lichaam =>
- B bang voor ziekte =>
- C symptomen snel toeschrijven aan somatische oorzaak =>
- D vaak komen met vage klachten.

Reattributie speelt in op stap C.

Met Reattributietechnieken stimuleer je de patient maximaal om zelf een link te gaan zien tussen klacht en stressfactor.

Dit gaat in 3 stappen:

- 1 zorg dat patient zich begrepen voelt; vraag vooral door over de klachten
- 2 verbreed nu de agenda: zowel lichamelijke als psychosociale / emotionele spoor volgen.
- 3 link leggen: patient loopt voorop, jij volgt op de voet.

Wil de patiënt geen link zien, ga dan niet voor hem uit lopen en hem meetrokken. Het is erg knap als jij een verband tussen klacht en stressfactor ziet, maar het gaat erom dat de patiënt een link gaat zien. Probeer het later, bijvoorbeeld met een andere klacht, gewoon nog eens opnieuw.

## 2 BELEID BIJ HARDNEKKIGE ONGERUSTHEID

Hierboven zagen we dat 'angst voor ziekte en kwetsbaarheid' één van de vier stappen vormt in het somatisatieproces; mensen bij wie deze ziekteangst op de voorgrond staat noemen we hypochondrisch. De huisarts kan hypochondrie herkennen aan de steeds weerkerende ongerustheid, ook na herhaaldelijk geruststellen.

Voordat je mag concluderen dat geruststellen bij bepaalde patiënten niet helpt, is het goed eerst nog even te kijken of je het 'gewone' geruststellen wel optimaal hebt uitgevoerd. Daarom volgt hier eerst een paragraaf over 'effectief geruststellen'. Vervolgens geven we aan wat je als huisarts kunt doen bij patiënten die na herhaald optimaal uitgevoerde geruststelling toch steeds weer met ongerustheid komen.

### 2.1 Effectief geruststellen

Geruststellen is iets wat elke huisarts dagelijks doet. Toch wordt er in de literatuur over gespreksvoering weinig over gezegd, vaak wordt zonder meer gesteld: "u stelt de patiënt gerust". Voor het 'slecht nieuws gesprek' bestaan concrete richtlijnen, maar hoe voer je een 'goed nieuws gesprek'?

De Engelse psychiater Bass geeft de volgende aanwijzingen.

- De timing is belangrijk: laat eerst merken dat je de bezorgdheid van de patiënt gehoord hebt, doe dan in elk geval lichamelijk onderzoek, vertel duidelijk je conclusies, zodat de patiënt weet waarop je geruststelling gebaseerd is

- Zeg erbij dat je ervaring hebt met dit soort problemen, dat maakt het voor de patiënt makkelijker om met jouw oordeel mee te gaan
- Huisartsen zijn geneigd de mate van ongerustheid die de patiënt aangeeft af te zwakken ('ik begrijp dat u zich een beetje bezorgd maakt'), beter is juist de bezorgdheid versterkt weer te geven ('ik heb de indruk dat u doodsbang bent dat dit weer een hartaanval wordt'), dan voelt patiënt zich meer (h)erkend. Dit vereist wel enige oefening. [Bass 1990]

## 2.2 Stoppen met geruststellen

Wanneer moet je stoppen met geruststellen? Als je iemand voor dezelfde klacht twee keer degelijk hebt gerustgesteld heeft een derde keer geen zin. Als iemand steeds over een nieuwe klacht opnieuw geruststelling vraagt zal het iets langer duren voor je het gevoel krijgt dat dit een herhaling van zetten is, die niets oplevert. Bass waarschuwt ons dat wij als huisartsen te lang doorgaan met geruststellen, dat we teveel aanvullend onderzoek ter geruststelling doen terwijl dit de ongerustheid alleen maar aanwakkert ('er moet toch iets zijn, anders zou de dokter dit allemaal niet laten onderzoeken'), en dat de regelmatige afspraken, die bij doctor-shopping zo nuttig kunnen zijn, hier averechts werken. De angstige patiënt raakt verslaafd aan geruststelling door de dokter. Elk consult doet de angst even dalen, maar daarna vlamt de angst juist weer op wat noopt tot opnieuw geruststelling vragen (vergelijkbaar met rituelen bij dwangstoornissen).

Hoe stop je met geruststellen? Dit kun je in het algemeen heel direct en congruent aanpakken: 'Ik heb u nu drie keer tevergeefs gerust proberen te stellen, zou het zin hebben dit een vierde keer te doen, denkt u? Ik ben van plan daarmee te stoppen. Laten we zoeken naar een manier waarop u zelf leert met uw ongerustheid om te gaan'. Het kan nuttig zijn gezinsleden hierbij te betrekken. Zij moeten ook stoppen met geruststellen.

## 2.3 Drie technieken voor verder beleid bij ongerustheid

Als het je lukt te stoppen met geruststellen, hoe ga je dan verder met de patiënt, die zelf nog hardnekkig ongerust blijft? Salkovskis, psycholoog in Oxford, geeft drie cognitieve/ gedragsgerichte technieken aan. Hij beschrijft twee manieren van ingaan op de meest alarmerende gedachte, deze zijn vooral geschikt bij patiënten die steeds meer onderzoek en verwijzing vragen, vaak voor steeds dezelfde klacht. Ten derde beschrijft hij hoe de techniek van exposure bij ziekteangst toegepast kan worden. Exposure is vooral geschikt bij vermijdingsgedrag of dwangmatig tobben.

*Ingaan op de meest alarmerende gedachte* Hierbij zet je achtereenvolgens onderstaande stappen.

- Vraag de patiënt welke alarmerende gedachten hij/zij over de klacht heeft, hoe groot acht de patiënt de kans hierop? hoe sterk heeft de patient behoefte aan geruststelling?
- Doe een 'final test' (laatste, beslissende test), dit kan lichamelijk onderzoek of aanvullend onderzoek of zelfs gerichte verwijzing zijn. Kies echt de test die voor de gevreesde ziekte het betrouwbaarst is, dus bij angst voor coronairlijden een inspanningsECG en geen gewoon ECG. Leg uit dat je dit niet nodig acht voor patiënten lichamelijke gezondheid, maar wel als psychologische stap. Leg de resultaten uit.
- Laat de patiënt opnieuw alarmerende gedachten noemen en de kans schatten en de behoefte aan geruststelling aangeven. Als hij/zij gerust is en blijft, is het probleem opgelost.

- Blijft de ongerustheid, dan moet je nu concluderen dat ook het betrouwbaarste medisch onderzoek de ziekteangst niet wegneemt. De angst zal blijven, tenzij de patiënt de angst als probleem aan wil pakken, waar vaak verwijzing naar een psycholoog of psychiater voor nodig zal zijn.
- Komt de ongerustheid na enige tijd weer op, laat dan opnieuw de kans op de alarmerendste kwaal scoren. Dit geeft een opening om te bespreken hoe geruststelling de ziekteangst, na een korte daling, doet opvlammen; geruststellen houdt bij u de angst in stand.

*Uitdagen van de alarmerende gedachten* Dit is een andere manier om in te gaan op alarmerende gedachten. Ook hier zet je achtereenvolgens de onderstaande stappen.

- Vraag naar de meest alarmerende hypothese: 'wat denkt u als ergste over deze klacht?'
- Hoe groot acht u de kans hierop? Vraag door naar argumenten.
- Ziet u ook een andere mogelijke verklaring voor de klacht? (alternatieve hypothese)
- Hoe groot acht u de kans hierop? Vraag door welke argumenten hiervoor pleiten?
- Schat nu opnieuw de kans op de alarmerende hypothese. Deze blijkt vaak dan veel lager uit te vallen. Dit maakt het voor de patiënt vaak acceptabel om de alternatieve hypothese te geloven.

*Exposure* De ziekteangst wordt hier benaderd analoog aan de aanpak bij andere angststoornissen. Bij agorafobie stimuleren we de patiënt zich stap voor stap weer naar buiten te wagen, we zijn niet geneigd te zeggen: blijf voortaan maar binnen en laat je partner de boodschappen maar doen. Bij ongerustheid zijn we meer (te veel) geneigd tot zo'n toedekkende houding: 'maak je maar niet ongerust en laat de dokter het geruststelwerk maar doen'. Om hardnekkige ongerustheid te verminderen is ook hier 'exposure' nodig. Stimuleer de patiënt zich bloot te durven stellen aan gezondheidsangst, in plaats van de angstgevoelens te ontlopen. Je kunt hierbij kiezen tussen drie manieren:

- vraag de patiënt zijn gezondheidsangsten thuis op te schrijven: opschrijven vereist dat je de angst toelaat en niet meteen wegdrukt
- niet vermijden maar opzoeken van angst oproepende prikkels. Dit kan voor een tobber betekenen een verplicht uur per dag tobben over de gezondheid. Voor iemand die contact met ziekte of dood vermijdt kan het betekenen op ziekenbezoek te gaan.
- paradoxaal: geef de patiënt de opdracht 'probeer een hartaanval/ pijn/ ... te provoceren'. Vaak blijkt dan dat mensen zich opeens realiseren dat ze helemaal niet denken dat dit kan => alle omzichtigheid waarmee ze de klacht uitlokkende situaties vermijden is onnodig.

Als het via deze technieken lukt de patiënt te laten zien dat niet zijn lichaam het probleem is maar zijn ziekteangst, wordt de kunst dit inzicht consequent te blijven benoemen steeds als de ziekteangst weer speelt. Misschien komt er een moment dat de patiënt voelt voor verwijzing naar tweedelijns cognitieve gedragstherapie. Daarmee worden goede resultaten geboekt: Emmelkamp rapporteerde in 1994 dat rond de 70% sterk verbeterd.



# Dankwoord

Mijn ouders hebben mij Netty genoemd. Zelf veranderde ik dat in Nettie, zodra ik alle letters kon schrijven behalve de y. Die eigenwijsheid konden mijn ouders waarderen, en dat is niet bij die ene keer gebleven. Lieve Mama en Papa, daar heb ik veel aan, en daar ben ik jullie dankbaar voor. Het veranderen van die y in een ie zegt nog iets over mij. Veel gaat me makkelijk af, en dat ene stukje wat ik (nog) niet kan, neig ik te schrappen. Die neiging is niet handig, als je een proefschrift wilt schrijven. Ik dank dan ook in het bijzonder de mensen, die mij geholpen hebben om iets moeilijks niet te schrappen, maar het te durven proberen.

Gerrit Locher, jij hield mij af van een veilig beperkt onderzoek naar het rode oog, en stimuleerde mij een onderzoeksidee door te zetten dat voor mij de kern van de huisartsgeneeskunde raakt.

Janny Dekker en Joan Boeke, jullie hebben mij de CWO binnengelokt. Daardoor heb ik het aangedurfd mijn stille wens om onderzoek te gaan doen om te zetten in een echt plan.

Beste CWOers, jullie met z'n allen hebben mij laten voelen dat onderzoek, zelfs statistiek, niet eng is maar leuk. Met alle scholingsuren, weekends, en de eerlijke feedback op elkaars onderzoek, zonder stiekeme bijbedoelingen of belangen hebben jullie het onderzoeksvuur in mij brandend gehouden. Dat ik als voorzitter soms aanbrandde, heeft jullie gelukkig niet verast.

Linda Gask, mother of the reattribution model, at my first visit to Manchester you listened carefully to my plans for a reattribution trial. You vividly commented my rudimentary ideas about modifications, and you eventually stimulated me to make use of symptom diaries. Your encouraging attitude helped me to establish the intervention.

De Zwolse werkgroep somatoforme stoornissen heeft mij laten meegenieten van hun rijke multidisciplinaire ervaring met somatiserende patiënten: huisartsen Harm Knol, Christiaan Meijer, en Saskia Bakker, fysiotherapeut Aart te Velde en psychiater en Felix Gimbrère, jullie hebben mijn klinische blik verscherpt. Dankzij en samen met jullie konden we uiteindelijk de reattributionstraining laten proefdraaien in de Drentse Warffumcursus.

Douwe de Vries, aan onze woensdagavonden bewaar ik warme herinneringen. Uitstellers zijn we allebei, en zo praatten we uren over onze studententijd, wederzijdse

kinderen, dokteren, mooie boeken, en dan opeens zetten we in 1 uur met topconcentratie een complete huisartsentraining op poten. Tijdens de trainingen was je voor de oefenende huisartsen afwisselend een overtuigende somatiseerder en een inspirerend feedbackgever.

Van de mensen die aan het onderzoek hebben deelgenomen, bedank ik allereerst de patiënten. Zij waren bereid samen met hun huisarts op een nieuwe manier naar hun klachten te kijken, terwijl velen van hen helemaal niet zulke positieve ervaringen met dokters achter de rug hadden. Dankzij de trouw waarmee de patiënten vier keer een dik pak vragen invulden, kon dit onderzoek slagen.

De huisartsen die deelnamen aan het Maastrichtse deel van het onderzoek, leverden daarmee op afstand ook een belangrijke bijdrage aan het Amsterdamse onderzoek. Dank aan W van den Broek, B Bruls, R Costongs, P van Dijk, GJ Dinant, J Eussen, G Govaert, R Helmers, P Hulshof, V Kaiser, R Leclercq, M van Nunen, H Paas, R Panhuysen, H van der Ploeg, J van Proosdij, J van Putten, PJ van Schendel †, H Schönberger, F Soomers, J Soomers-Turlings, J Stoffers, C Stuurman, J Veldhuizen, P Voorhoeve, B de Wit, H Ypma, H Zwanikken en V Zwietering.

Veel nabijer zijn mij de huisartsen van het Amsterdamse onderzoeksdeel geworden. Jaap van Alkemade, Meggy van de Biggelaar, Gé Bontenbal, Janny Dekker, Roel Drijver, Ton Geerlings, Menno Haverkort, Wim Miltenburg, Renée Oederik, Jan Kees de Ridder, Wim Speelman, Karin Verschoor, Renée van de Vijver-Fesevur, Petra Wempe, Cora de Wolff, jullie waren de spil van het onderzoek: jullie voerden de consulten uit waar het in de trial om draaide. Als controle huisarts werden jullie bewust aan je lot overgelaten, opdat je vooral je gewone beleid ongestoord zou voortzetten, terwijl wel hele middagen een stel studenten in je kaarten en PC kwamen vissen. Als interventie huisarts deed je opgepropt in een klein VU kamertje urenlang rollenspelen, met slechts een rijstmaal als troost, moest je bandjes opnemen van je moeilijkste consulten ook als je dat nog nooit gedaan had, en je schuldig voelen als je het niet deed. Mij staat nog scherp bij dat jullie zo vaak vonden dat je ‘niet genoeg’ deed, dat het ‘zo toch nooit effect kon hebben’, en jullie verbazing als een patiënt met een klein duwtje al tot reattributie kwam ‘dat zal niet door mijn inbreng komen’. Jullie inzet heeft dit onderzoek mogelijk gemaakt, en jullie openhartige commentaar heeft de reattributietraining tot een goede cursus gemaakt. Bedankt!

Joost Zaat, begeleider van het eerste uur: je aansporingen ‘kan dat niet korter?’ ‘moet dat er echt in?’ ‘concreter graag’, hebben toch tot 5.085 regels tekst geleid. Tsja .....

Van je felle commentaar op mijn eerste artikel, mijn broddellapje, schrok ik wel, maar nuttig was het zeker. Toen je de VU verliet legde je een briefje op mijn bureau: ‘bij tegenslagen in het onderzoek: Bach’s vijfde cellosuite helpt!’ Inderdaad.

Henriëtte van der Horst, jij formuleerde ooit als taak voor de (beoogd) copromotor: bewaken van het welzijn van de promovendus. Dat heb je voor mij wel gedaan. Hoe vaak ik ook tobbed bij je binnenkwam, mopperde over mijn trage voortgang, twijfelde aan de waarde van alles wat ik onderzocht had en zeurde over de omslachtigheid van al dat wetenschappelijke geschrijf, toch beweerde jij glashard dat het begeleiden van mij het leukste deel van je werk was. Steeds wist je me zover te krijgen dat ik zelf een nieuw plan maakte waarmee ik getroost weer aan de slag ging. Jouw carrière loopt met een ijzeren regelmaat een paar jaar voor de mijne uit, dus toen jij van de VU leek te gaan vertrekken, vreesde ik al dat ik je binnen enkele jaren achterna zou moeten gaan. Alleen daarom al ben ik blij dat je opnieuw naar de VU komt. Het bureau naast me staat leeg, je bent welkom!

Piet Portegijs, onze samenwerking is in een snelkookpan gaar geworden: tussen Hemelvaart en Pinksteren, terwijl alle faxen onbereikbaar waren en de e-mails elkaars attachments nog niet begrepen, brouwden wij uit jouw en mijn aparte onderzoeksídee een gemeenschappelijke subsidieaanvraag. Al gauw kwamen onze verschillen bovendien: waar jij wilt uitbreiden wil ik inkorten, waar ik op elke vraag een antwoord zoek, bedenk jij bij elk antwoord meteen nieuwe vragen. Die rolverdeling hebben we vijf jaar volgehouden, en daar is het onderzoek een stuk beter door geworden. Dankzij jou is in dit onderzoek geen punt onbediscussieerd voorbij gegaan.

Bert Schilte, mijn Maastrichtse onderzoeksbroertje. Jouw vrolijke kop achter de verse vlaai bevestigde het ‘vakantiedaggevoel’, dat al in de trein naar Maastricht begonnen was. Al discussiërend wandelden we rond het Debiéplein, en dan wist ik weer dat we eigenlijk voor ons plezier werken. Toen ik klem raakte in de analysefase ben je me zeer solidair te hulp geschoten, terwijl amper een maand later jouw nieuwe praktijk zou starten: praktijkpand, ziekenfondscontract, regeling met je voorganger, alles moest nog, maar jij kwam in alle rust een hele dag mij helpen. Ik was heel blij het geploeter te kunnen delen met een maat, die met precies evenveel betrokkenheid de andere helft van de data zat te bewerken. Jouw sportiviteit heb ik leren kennen toen jij in de eindspurt zat en ik nog van hartelust met kritiek bleef komen. Jij hoorde niet alleen alles welgemoed aan, maar bracht het zelfs op hele artikelen nog om te gooien.

Jacques van Eijk, onze samenwerking is tijdens dit onderzoek stukgelopen en dat is treurig. Wel dank ik je voor de wervende kracht waarmee je mij het EMGO binnengetrokken

hebt. Met je harde eis ‘zet het eerst maar eens op een A4tje’ heb je mij geholpen mijn onderzoeksidee concreet te maken

Marten de Haan, je bent als tweede eerste promotor in een rijdende trein gestapt. Veel stations waren al gepasseerd, maar gelukkig heb je de verdere route nog weten te beïnvloeden met je vele praktische opmerkingen. De lijst met vragen die jij als frisse nieuwkomer in de projectvergadering stelde heb ik bewaard: een betere voorbereiding op mijn verdediging bestaat er niet.

André Knottnerus, met weinig maar wel precies de juiste woorden heb jij op essentiële momenten dit onderzoek bijgestuurd. Terwijl jouw eerste verantwoordelijkheid lag bij het Maastrichtse zusterproject heb je de belangen van ons Amsterdamse onderzoek ruim behartigd.

Veel mensen hebben aan de voortgang van het onderzoek bijgedragen. De psychiaters Ton van Balkom en Christina van de Feltz-Cornelis: jullie becommentarieerden de syllabus voor de interventie-huisartsen zo positief, dat die meteen klaar was. André van Loenen, die als wetenschappelijk stagiair een pilot onderzoek uitvoerde met de schriftelijke DIS. Jij toverde zo handig vragenlijsten en resultaten uit je PC dat ik het daarna nog steeds niet kon. Studentassistenten Saskia de Bruin, Helma Lebbink, Inge Mathijssen, en alweer André van Loenen: uit 12 huisartspraktijken visten jullie de veelkomers op, een forse klus vooral omdat de meeste praktijken juist tijdens de drie zoekjaren van groene kaart naar computerjournaal waren overgestapt. Marlies Boon, die non-respons onderzoek uitvoerde: twee jaar na de insluitingsperiode wist jij nog gegevens te achterhalen.

De belangrijkste praktische ondersteuning in dit onderzoek kwam van Inge van der Leden: ‘geef maar aan mij’, ‘tuurlijk lukt dat nog’, ‘neem een paar dropjes, ik kom er aan’, ‘voor jou altijd’. Hoe vaak heb je mij gered, als ik weer eens een last-minute klus op je al volle bordje legde. Terwijl je radio gewoon doorjengelde, haalde jij patiënten over toch maar mee te blijven doen (‘u bent echt heel belangrijk!’), mat je duizend VAS schaaltes op en tikte je zelfs bij ‘kriebelbeestjes in het bloed’ een passende ICPC code in. Het is maar goed dat je in de eindfase net even van de VU vertrokken was, anders had ik de lay-out, de omslag en al het eindredactie-priegelpakket nooit zelf gedaan.

Het leven op de vijfde verdieping betekende voor mij allereerst Gerlof Valk: kamergenoot, klankbord en gesprekspartner, we zaten dicht bij elkaar, en niet alleen in meters. Didi Kriegsman, overbuurvrouw, met wie ik ‘over de heg’ zo heerlijk kon afreageren.

Je hebt me daarmee erg gesteund. In jouw blauwgewalmde pijpenlaatje wist je alle informatie te vinden die ik zocht, meestal uit je eigen hoofd. Els Pronk, hartelijk en degelijk mens, je hebt me behoed voor het vergeten van beloofde rapportages, agendapunten en telefoontjes en dit alles met een toegeeflijk lachje. Valentien Blom, je fleurt de gang op met je drie liefdes muziek, discussies en zwarte motor.

Gelukkig was er ook nog leven buiten de VU. Tinka Prast, lopend door de duinen hadden we deze jaren wel belangrijker dingen te bespreken dan mijn onderzoek. Toch ben ik benieuwd hoe jij er tegenaan kijkt, zo'n echte doktersinterventie, kort en oppervlakkig vergeleken met de psychotherapie die jij geeft.

Han Hofstee, praktijk-collega sinds 1984. Jouw flexibiliteit is groot. Daar heb ik wel erg veel gebruik van gemaakt: hoeveel spreekuren hebben wij geruild omdat ik naar Maastricht / begeleidingscommissie / huisartsentraining / onderzoekerscursus 'moest', en dat nog wel voor een onderzoek dat nou juist niet gaat over de 90% patiënten voor wie jij een goede huisarts wilt zijn.

Tenslotte, de belangrijkste reisgenoten in de eindfase, mijn paranympfen en vriendinnen Jolijn de Graaff en Lies van Boxtel. Lies rustig en niet-oordelend, Jolijn juist wel oordelend en eisen stellend, samen geven jullie mij precies de goede duwtjes. Jullie wisten mij zelfs in bontcapejes en dirndljurken te hullen, dat was nog nooit iemand gelukt. Op het juiste moment ontvoerden jullie de kinderen naar de zwarte markt, waarmee jullie mij een saai maar productief weekend bezorgden.

Lieve Herke, lieve Marieke, jullie zorgden dat alle andere weekends niet saai en niet productief waren, en dat mijn leven gewoon gezellig bleef (meestal, toch?).

# Curriculum vitae

**Jeugd** Nettie Blankenstein (Annette Hendrina) werd op 20 augustus 1954 geboren in Leiden, waar ze ook opgroeide. In 1972 behaalde zij het eindexamen gymnasium β aan het Christelijk Lyceum Dr. Visser 't Hooft te Leiden. Daarna werkte zij een jaar als medewerkster kinderleiding en huishouding op vormingscentrum Kerk en Wereld te Driebergen en een jaar als verpleeghulp in het Leiderdorpse verpleeghuis Leythenrode.

**Studietijd** Vanaf 1974 studeerde zij geneeskunde aan de Vrije Universiteit te Amsterdam. Van 1975 tot 1977 studeerde zij daarnaast filosofie aan de centrale interfaculteit van de VU. Tijdens de studiejaren was zij actief in de MFVU, de vakbond van medische studenten aan de VU. Van 1975 tot 1980 werkte zij als student-assistent mee aan het opzetten en uitvoeren van het onderwijs in de medische filosofie. In 1982 haalde zij haar artsexamen. Van 1982 tot 1986 was zij docent medische vraagstukken aan de Amsterdamse sociale academie CICSa. In 1983/84 volgde ze de huisartsopleiding, weer aan de VU.

**Huisarts** In 1984 zette zij samen met Han Hofstee een praktijk op als 'wilde vrije vestiging' te Naarden, waar beiden vijf jaar als huisarts bleven werken. De samenwerking met Han werd voortgezet: sinds 1989 werkt zij parttime als huisarts in zijn praktijk in Badhoevedorp. Naast het werk als huisarts is zij sinds 1986 verbonden aan de vakgroep huisartsgeneeskunde van de VU, eerst als universitair docent in het basiscurriculum en van 1990 tot 1994 als coördinator van de sectie basiscurriculum. Sinds 1994 maakt zij als onderzoeker deel uit van de onderzoeksgroep huisartsgeneeskunde van het EMGO instituut (extramuraal geneeskundig onderzoek) van de VU. Daarnaast coördineert zij sinds 2001 de wetenschappelijke vorming binnen de huisartsopleiding.

**Commissies** Van 1990 tot 1996 was zij lid van de facultaire emancipatiecommissie geneeskunde, vanaf 1992 als voorzitter. Vanaf 1989 maakt zij deel uit van de commissie wetenschappelijk onderzoek van het Nederlands huisartsen genootschap (NHG), sinds 1995 als voorzitter. Binnen de NHG kaderopleiding huisartsgeneeskunde is zij vanaf de start in 1997 lid van de cursuscommissie Vlaams-Nederlandse onderzoekers opleiding huisartsgeneeskunde. Vanaf de oprichting in 1997 is zij lid van de programmacommissie van het NHG fonds alledaagse ziekten. In 2001 trad zij toe tot de juist door de VNVA (vereniging van Nederlandse vrouwelijke artsen) ingestelde werkgroep vrouwelijke huisartsen in academia.

**Thuis** Nettie woont met zoon Herke (12 jaar) en dochter Marieke (7 jaar) in woongroep De Stal in het oostelijk havengebied van Amsterdam.